Cheaha Mental Health Center
Strategic Plan, 2010 – 2012

Prepared For
Cheaha Regional Mental Health / Mental Retardation Board, Inc.

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Table of Contents

I. Executive Summary

Cheaha Regional Mental Health / Mental Retardation Board, Inc., doing business as Cheaha Mental Health Center, has been serving the behavioral health needs of adults, adolescents, and children in East Central Alabama for more than 40 years. Organized as a public, non-profit corporation under the Authority of Alabama Act 310 of the 1967 Alabama Legislature, Cheaha Mental Health Center (Cheaha) is governed by a 21 member Board of Directors appointed by local governments. Cheaha provides a continuum of services for persons with intellectual disabilities, serious mental illness and substance abuse disorders in a four county area in east central Alabama, which includes Clay, Coosa, Randolph, and Talladega Counties.

Cheaha's current mission is "to provide effective quality services for persons whose lives are affected by mental illness, mental retardation, or substance abuse. Cheaha MHC is committed to providing these services with respect for individual dignity and privacy, and in the least restrictive environment necessary to promote recovery. Services and programs shall be provided in a cost effective manner. Individualized services shall be developed based upon the reported and requested needs of consumers and their families.

To ensure services are provided in accordance with its mission, Cheaha recognizes the need for continuous quality improvement. Essential to these efforts is the inclusion of input from consumers, family, cross departmental and cross discipline staff obtained through annual surveys and meetings. Cheaha will continue to use Quality Improvement methods to develop a functional and responsive approach to performance improvement."

OPEN MINDS was engaged to develop a strategic plan for Cheaha Mental Health Center that achieved two goals:

- Successfully plan, organize, and facilitate a strategic planning process for Cheaha Mental Health Center that engaged the governing body, management and staff in a process of learning, exploration and formal planning for the future of the organization.

- Produce a strategic plan for Cheaha Mental Health Center that establishes a foundation for improvement of existing services and organizational functioning, clarifies the organization's vision and mission; is consistent with organizational values; and will serve as a blueprint for the organization's successful entry into new markets, the development of new services and enhanced financial performance.

To understand the process and results of this strategic planning effort, it is important to establish the context within which the project was initiated. Heretofore, planning was considered to be a management function for which the governing body retained "policy approval." Generally, management plans were developed within the construct of annual program budgets or as executive directives. For the most part, planning was neither an organization-wide nor an integrated process. Rather, it supported disability or program-

specific activities. Organizational performance expectations were not established, monitored or evaluated.

In late 2009, concurrent with the hiring of a new Executive Director, the Board of Directors established a Transition Committee to oversee the creation of a Plan of Work for the new chief executive. One of the requirements of that plan was to recommend a course of action regarding the development of the organization's first strategic plan. Drawing on the new executive's work that created a management team and engaged the Board of Directors in a comprehensive orientation to Cheaha's programs and services, the strategic planning process balanced the competing demands of a future orientation with the realities of building a framework for current organizational performance.

As a result of the analyses of both Cheaha's current capabilities and market positioning and the evolving Alabama health and human service market it was concluded that Cheaha pursue seven strategic initiatives that will position it for growth and stability over the next three years. The recommended strategic initiatives include:

- Leadership Initiative (#1): To exercise accountable leadership through engaged governance and best management practices. Objectives include: review, validate and/or update the Vision, Mission and Core Values of the organization in the context of the strategic imperatives driving this planning process; prioritize strategic initiatives and allocate resources accordingly; establish organizational performance expectations and metrics; monitor and evaluate organizational performance on a continuing basis; and, incorporate evaluative results into a cycle of annual planning and performance improvement.

- Workforce Development Initiative (#2): To strengthen and enhance the workforce as a primary means to achieve quality services and organizational performance. Specific objectives include: assess staff development needs for both current and future skills and implement appropriate training, education and interventions; develop an employee performance plan that links current position descriptions, performance expectations and evaluations with performance-based pay; create a manpower plan that matches staffing levels of appropriately trained/credentialed staff with the nature and volume of work and program services based on industry manpower standards; update personnel policies to reflect current Cheaha operations and contemporary human capital management approaches; revise time-off policies to balance the value of legitimate needs of employees with the financial implications for current operations and long-term financial stability; and, evaluate the currency, competitiveness and cost-benefit of the employee compensation plan including both pay and benefits.

- Quality Initiative (#3): To improve the quality of clinical services and administrative functions through the systematic measurement of performance with a focus on future results. Key objectives include to identify and implement evidence-based and emerging best practices; establish and monitor outcome expectations; evaluate the efficiency and effectiveness of clinical services and administrative activities;

measure consumer, family, staff and payer satisfaction; and, explore accreditation at both the program and organization levels.

- Clinical Services & Supports initiative (#4): To improve and expand the continuum of clinical services and supports that are self-financed and generate an operating margin. After assuring that required services are provided, new services and programs will be pursued that draw on organizational competencies and have an acceptable return on investment. Initially, the following service improvements or expansions have been identified:
    - Intellectual Disabilities Services
        - Develop apartment-based residential living in Talladega
        - Develop respite service in Talladega – private pay market
    - Mental Illness Services
        - Increase Basic Living Skills
        - Develop & Implement Mobile Therapist Model
        - Increase Case Management
        - Increase the Use of Group Therapy
        - Pursue Primary Care Integration opportunities
        - Expand & Improve Child & Adolescent Services
    - Substance Abuse Services
        - Improve occupancy rate for residential services
        - Explore recovery home residential model
        - Improve Drug Court use of treatment services to achieve break-even
- Technology Initiative (#5): To enhance clinical, support and administrative practice through acquisition and effective application of technology. Primary objectives include to develop a Technology Plan that addresses clinical needs for telehealth, on-line and computer-based services and on-line support groups; management needs for an integrated electronic health record and billing system; and, technology security and development. Given limited resources, technology developments must be prioritized.
- Finance Initiative (#6): To assure financial viability and promote the growth of the organization. Specific objectives include to accumulate 3 months operating cash;

establish clear performance metrics for efficiency and effectiveness; develop and deliver timely management reports to support strategic and operating goals; maximize rental income from center properties; and, reduce/contain support expenses.

- Communication Initiative (#7): To actively communicate the Vision, Mission, Core Values and Performance Outcomes of the organization. The key objective is to engage and build working relationships with consumers & families, staff, local governments, allied health and service organizations, communities and citizens-at-large

Given the significance of these strategic initiatives to building Cheaha's foundation for viability and future growth, and the concurrent demand of these initiatives for management and human resource allocation, Cheaha will undertake an implementation project during Calendar Year 2011. By focusing the implementation of strategic initiatives and objectives around improving the performance of a specific service line, Cheaha will create a learning laboratory that allows it to: build the organizational capacity to undertake strategic development; incorporate best clinical and administrative practices into ongoing operations; create a culture of performance throughout the organization; achieve results that have immediate impact; and "learn by doing." The implementation project will focus on performance improvement for Cheaha's MI Outpatient Services.

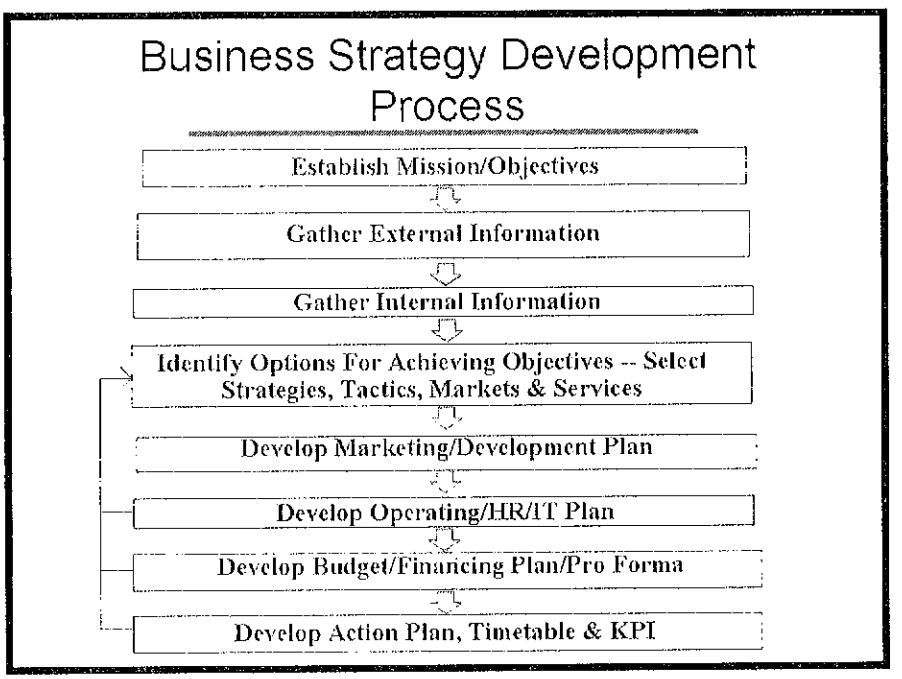
The strategic plan that follows summarizes the external and organizational analysis that lead to these strategic initiatives and provides strategic and operational considerations about the recommendations, as well.

II. Scope & Methodology

The *OPEN MINDS* team developed an approach and methodology for facilitating the development of a strategic plan for Cheaha that is based both on nationally-recognized best management practices and also on our extensive experience in the field. This approach is described in detail within this section of proposal. All the components of the plan — the service line analysis, the market opportunity analysis, the plan itself, and the resulting key performance indicators — were structured in a way that can be easily updated by the Cheaha team in intervening years.

OPEN MINDS believes that organizations in the behavioral health and social service field need to adopt demonstrated best practices in strategy development, planning, and strategic management. Previously, many provider organizations used a 'community needs assessment' model for planning — an appropriate model when provider organizations had negotiated, cost-plus contracts with government payers. In most current environments, strategic plans need to reflect the current mission, operating, and financial environment of the organization.

The prototypical best practice planning model involves a structured review of internal and external data; the development and review of options for action; the development of appropriate strategies and tactics; and the development of internal operating plans and key performance indicators to assure successful implementation of the strategy. The prototypical process (which was modified for Cheaha) is outlined in the diagram below.



OPEN MINDS initially created a project work plan and a list of requested information from Cheaha. From that information, *OPEN MINDS* was able to formulate a preliminary service line analysis for Cheaha's leadership.

OPEN MINDS held an initial onsite meeting with Cheaha's executive leaders on July 13, 2010. After reviewing preliminary findings, the management team received a briefing on current developments in services, funding and competition. That educational experience was followed by the leadership team participating in a SWOT analysis. Finally, the Board's Strategic Planning committee met in the afternoon to: review the external environmental scan and preliminary results of stakeholder interviews; receive a report on the SWOT Results from the Leadership team; solicit Board Member input; identify Strategic Initiatives and discuss next steps.

A range of stakeholder surveys were utilized to garner additional external input into the strategic planning process. The first was a series of telephone interviews conducted by *OPEN MINDS* with individuals identified by Cheaha's leadership as important to its future. In addition, Cheaha designed and administered a Consumer and Family Survey and an Employee Survey to solicit input. While consumers and families annually participate in a state sponsored satisfaction survey, the Employee Survey represented the first formal use of employee input into agency-wide planning. The feedback from these instruments was used by Cheaha's leadership to influence its analyses and its subsequent decisions regarding both this Strategic Plan and the FY 2011 budget.

Based on all of these findings, a Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis was created and the results were shared with Cheaha leadership. A summary of the Cheaha leadership and Strategic Planning Committee conclusions is located in Section VI of this report.

A second work session and consultation visit was held with the Cheaha leadership and Strategic Planning Committee over the course of two days on August 25th and 26th. The visit culminated with a presentation to the Cheaha Board of Directors on Thursday, August 26th. At that time, the Strategic Initiatives and Key Objectives were outline for the governing body. In addition, discussion was held regarding the need for Cheaha Board and staff leadership to review the agency's Vision, Mission and Core Values. The Board approved the creation of an ad hoc committee to undertake the review with Board members to be appointed by the Chair. Subsequently, drafts of the Vision, Mission and Core values have been developed for further review and decision-making.

The Strategic Initiatives, Key Objectives and an Implementation Project are outlined in Section VII of this report.

The Cheaha Mental Health Center Strategic Plan 2010 -2012 report is structured in eight (8) sections followed by four (4) appendices.

III. National Trends in Health & Human Services

OPEN MINDS conducted a comprehensive review of national and statewide trends in the health and human service field at the national, state, and local level. A rapid evolution in the shifting market landscape is occurring due to the convergence of payer preference for improved provider performance and efficiency and a push for consumer choice within the confines of a framework of cost controls. In addition to these market forces, implementation of recent landmark federal legislation - including both the Paul Wellstone, Pete Domenici Parity Act which received final approval in October, 2008 and the Patient Protection and Affordable Care Act of 2009 – will have profound effects on the delivery of health and human services. These market shifts and the implications for Cheaha are continued below.

A. Behavioral Health & Social Service Industry Trends

An understanding of the macroenvironment is a key element in creating organizational strategy. While the more immediate microenvironment of current customers and current competitors drives short-term strategy and tactics, the overarching environmental changes create the framework for long-term vision and longer-term strategy. In the behavioral health and social service field, there are three domains of environmental change that are reframing the long-term vision of payers, care management organizations, provider organizations, and professionals in the field. In addition, strategic analysis of the impact of these domains requires a look at the unintended and unplanned synergistic effects of these shifting domains on organizational market position. The three domains with the most prominent impact on strategy development for Cheaha are:

- Domain 1: Shifting Resource Allocations, Responsibilities, And Relationships Between Public And Private Payers Of Health And Human Services
- Domain 2: Evolution In The Management Approaches And Organizations Used By Health And Human Service Payers To Manage Their Funds
- Domain 3: Changes In The Consumer Service Context, Including Modalities And Locations Of Care, Clinical Treatment Models, Technology, And Support Service Delivery

In the sections that follow, there is a brief summary of the major environmental trends in each domain along with identification of key strategic implications.

Domain 1: Shifting Resource Allocations, Responsibilities, and Relationships Between Public and Private Payers of Health and Human Services

Nationwide, spending on mental health treatment is increasing both in absolute dollars and as a percentage of total health care spending. Spending, however, has shifted in specific directions. Between 1986 and 2007, spending on inpatient services has

declined while outpatient spending has risen; pharmaceutical spending has risen from seven percent of total mental health expenditures to 35%, and responsibility for service provision has shifted increasingly from the federal government to the states.

The decline in share of spending on inpatient services reflects a move away from the delivery of treatment in traditional settings to non-traditional settings. The main drivers for this shift are changes in the way government finances health and human services. The adoption of federal waivers and increased cost-sharing between the federal government and the states has shifted more responsibility to the states to finance health and human services. The federal government, in turn, has given the states greater "discretion" in how funds are used in the provision of human services, although budget deficits, budget cuts, and Medicaid rule changes complicate the design and delivery of the desired/mandatory array of services.

Current trends are toward integrated funding, with two emerging models for financial and benefit management:

- Development of an integrated health/behavioral health model in state-administered systems
- Development of an integrated social service/behavioral health model in regional/county-administered systems

In both models, there is an increase in public sector use of a combination of competitive bidding, privatization, and risk/performance-based contracting in an effort to achieve cost containment and quality improvements.

In similar fashion, cost pressures have driven changes in employer provision of coverage for behavioral health services. Changes include employer cost shifting to the public sector; increased use of managed care; adoption of consumer-directed health plans; and the introduction of employee assistance programs.

Domain 2: Evolution in the Management Approaches and Organizations Used by Health and Human Service Payers to Manage Their Funds

Managed care as the primary cost control mechanism for health care has moved into the human services arena. Managed care principles are being applied to child welfare funding through privatization initiatives (and performance-based contracting), and are newly adapted to MR/DD through the disability care coordination concept. Behavioral health care in managed care models are now manifest in health maintenance organizations and other managed care plans, carve-out managed behavioral health programs, and in primary care case management (PCCM) models.

A variety of cost control options for payers are being used. Some avenues taken include limiting eligibility for coverage; reducing fees paid or services offered; increasing the 'acuity' of service delivery without increasing fees; setting arbitrary (non-clinical) limits

on units or dollars of certain services; and/or only paying for 'approved' treatments to include the use of evidence based practice criteria to limit financing.

The unfavorable cost environment (constrained budgets and increased demand for services) has led payers to evaluate alternatives to managed care. Disease management programs have arisen in an effort by payers to anticipate and proactively manage services to specific populations of beneficiaries with co-morbid chronic health conditions. State interest has also grown in public sector consumer-directed initiatives. Fifteen state Medicaid plans now offer cash and counseling programs and both Medicare and Medicaid allow for forms of health savings accounts.

With the passage by the federal government of parity legislation on October 13, 2008 and the limitations previously inherent in benefit plan designs related to behavioral health services eliminated health care sources are predicting a growth in the application of managed care principles in order to control the higher limit benefit plans that went into effect in January, 2010.[i]

Domain 3: Changes in the Consumer Service Context, Including Modalities and Locations of Care, Clinical Treatment Models, Technology, and Support Service Delivery

Aside from the changes in the financial resources flowing into the health and human service system and how payers choose to manage those funds, there are changes at the consumer service delivery level with widespread impact on stakeholders. Key changes in this area include:

- Shifts in dominant treatment modalities
- Shifts in dominant sector of service provision
- Human capital issues become "strategic"
- Increase in use of information systems and telecommunications technologies in the field

Shift in Dominant Treatment Modalities Dominant treatment modalities are now shifting from facility-based services (inpatient and acute care services, residential care, and nursing home care) to home and community-based services, including assisted living, day treatment, partial hospitalization programs, and clinic-based services.

Shifts in Dominant Sector of Service Provision The once dominant traditional mental health and addiction treatment system and its provider organizations, along with the traditional social service system and its provider organizations, are giving way to service delivery in non-traditional settings. At present, a larger proportion of behavioral health treatment is provided in primary care settings than specialty settings, to include primary care delivery locations; non-psychiatric specialists' locations; disability supports and senior services system; child welfare and juvenile justice system; adult corrections

system; and the education system. New impetus for this shift is provided by the trend to integrate or imbed behavioral health service provision with financing and delivery of other services.

Human Capital Issues Become "Strategic" Changes in service provision have created change in who provides services and how providers are compensated. Providers face an increasingly diverse profile of consumers requiring staffing capable and competent to address special and specialized client needs. Market rates paid for front-line staff are increasing as are requirements (and cost) for training and development. In general, the industry shares the nationwide trend of an aging workforce and its related costs. Executive team succession and replacement costs are rising. Efforts to control human capital cost pressures have led to a shift toward 'variable pay' for professionals based on productivity and performance, and increased use of temporary and contract staff. Recruitment, retention, and reimbursement issues are present throughout the industry, particularly with regard to foster families and home care aides.

Increase in Use of Information Systems and Telecommunications Technologies in the Field Shifts in treatment settings raise questions with regard to local capacity to provide increasingly complex services. This limiting factor is being faced and, in part, addressed by increased reliance on information systems and telecommunications technologies. Telecommunication and technological innovations permit services to be delivered in a less costly and intensive environment and can move treatment from delivery by specialists to generalists and less highly-trained professionals, including opportunities for self-care. On the flip side, technological changes in administration and treatment are disruptive and will require provider institutions to demonstrate the flexibility to adapt or face failure.

The environment facing the behavioral health and social service field is in flux, but is characterized by declining fee-for-service pricing and unit cost management; inflexible "commodity" relationship with payers and their agents; shifting burden of uncompensated care; challenges by new competition to shifting value chain position; investment capital, human capital, technology adoption; 'economy of scale' issue; and for non-profit providers, balancing their mission against the pressures of the current financial environment.

B. Parity and Healthcare Reform Legislation

The Paul Wellstone, Pete Domenici Parity Act is law. It was passed by Congress in 2008 and regulations to implement the law became effective in January, 2010. Below is a summary of the major provisions of Parity legislation:

- Eliminates barriers to mental health and substance abuse treatment posed by different insurance deductibles, lifetime coverage caps, and high copayments.
- Insurers are required to include benefits for any mental health condition listed in the latest edition of the Diagnostic and Statistical Manual for Mental Disorders.

- Requires group health insurance plans to provide coverage for mental health or substance abuse to cover all the disorders and conditions covered by the Federal Employees Health Benefits Program.

- Insurance plan copayments, yearly visit limits, and lifetime treatment limits for behavioral health must match those for medical health.

- Increased the mental health benefits protection afforded under the federal Mental Health Parity Act of 1996.

- The new law does not apply to Medicare patients, but does apply to Medicaid patients.

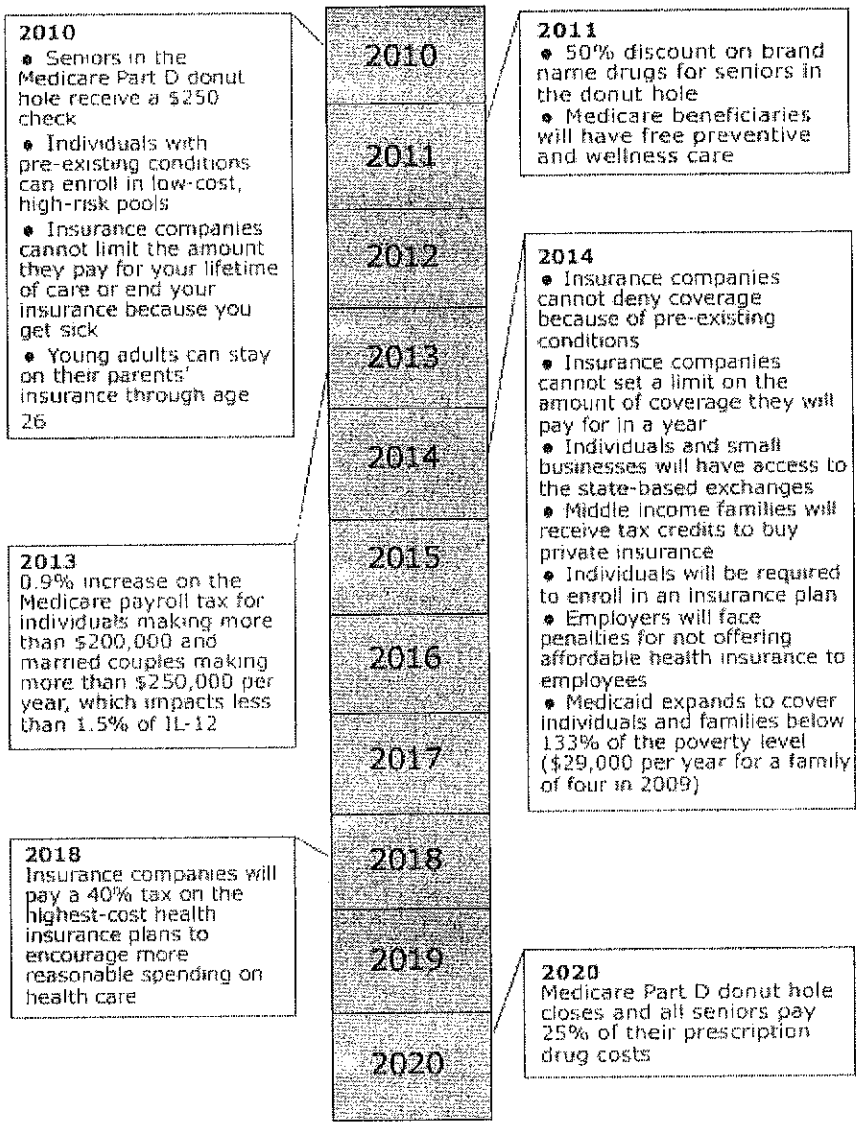
While Alabama has an existing mandate for coverage of serious mental illness, the Parity Act expands the mandate to include substance use disorders, as well.

According to Kaiser State Health Facts, 54% of Alabama residents have commercial health insurance provided either by an employer or by the individual. While it is unlikely recovery supports will be covered by any of the commercial insurance products, parity will result in mental health and substance abuse treatment being covered for almost 65% of the system's current clients.

Healthcare Reform and Innovation

The Patient Protection and Affordable Care Act (ACA) was signed into law in March, 2010. While there are a host of legal challenges currently underway, including Alabama's participation in a multi-state legal action challenging the constitutionality of some provisions of the Act, for now it is the law of the land. It is clear that if the new federal law is implemented, it will drastically change the delivery of behavioral health services in Alabama.

Some provisions of the ACA have already been implemented, while others are scheduled to become effective in later years. The following is a table summarizing key provisions of the ACA and when each is scheduled to become effective.



While the act as a whole remains controversial in many respects, the new law is replete with measures many visionary thinkers in the behavioral health field have only hoped would eventually intersect. This new approach to mental health and addiction services arising from the ACA emphasizes prevention, integrates behavioral health and primary care, expands access to underserved rural populations, improves workforce supports, focuses on the use of evidence-based practices and speeds the evolution toward recognition of the importance of mental health in overall wellness.

The following is a section by section analysis of the federal law with an emphasis on mental health and substance abuse. This analysis was derived from the work of Barbara Durkin, Senior Policy Analyst, National Association of State Alcohol and Drug Abuse Directors (NASADAD).

In summary, the law will impact mental health and substance abuse services in the following ways:

1. Prevention

Across every section of the bill, there is an emphasis on preventive health. Insurance plans are required to include prevention coverage for "evidence-based services." Without cost-sharing requirements. The bill creates the National Prevention, Health Promotion and Public Health Council composed of cabinet level and other high ranking officials as a way of sustaining research and focus on prevention. The Director of the Office of National Drug Control Policy is a member. Substance abuse and mental health are specifically identified as national priorities. The first report to Congress from this group is due July 1 of this year.

The law establishes a Prevention and Public Health Investment Fund. The goal of the Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. This will involve a dedicated and stable funding stream for prevention, wellness and public health activities. Authorized funding levels for the Fund are as follows: $500 million in 2010; $750 million in 2011; $1 billion in 2012; $1.25 billion in 2013; $1.5 billion in 2014; $2 billion in 2015 and each year after 2015.

Beginning in January of 2011, $100 million dollars in grants are provided to states for incentives for Medicaid beneficiaries to participate in programs for healthy lifestyles. These programs must be comprehensive and must address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower cholesterol and/or blood pressure, lose weight, quit smoking and address co-morbidities which would include depression.

The Director of the Centers for Disease Control (CDC) will award competitive grants to state and local government agencies for programs promoting individual and community health and preventing the incidence of chronic disease.

2. Integration of behavioral health and primary care

The coverage requirement for all forms of insurance, including Medicaid and Medicare, include parity for mental health and substance abuse. The law expressly includes mental health and substance abuse disorders among "chronic diseases" are to be addressed holistically. Alabama is given the option of enrolling Medicaid beneficiaries with chronic conditions (including MH/SA) into a health home which would be comprised of a team of health professionals and would provide a comprehensive set of medical services including care coordination.

The Act authorizes $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

A new program is funded to support school-based health clinics providing comprehensive and accessible preventive and primary care services to medically underserved children and families. Eligible applicants are school-based health centers or a sponsoring facility of a school-based health center. Each school-based health center must provide, at minimum, comprehensive primary health services. Mental health services (meant to include substance use disorder services) and assessments, to children and adolescents are included as comprehensive primary health services.

Competitive grants will be given to eligible entities, which would include state and local governmental agencies, for programs promoting individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or other activities consistent with the goals of promoting healthy communities.

Grants are provided to states or large local health departments to conduct 5-year pilot programs in the 55 to 64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions and ensure individuals with chronic disease or at risk for chronic disease receive clinical treatment to reduce risk. Mental health and substance use disorder screenings would be included as a public health intervention. Specifically, the legislation states interventions include "efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population."

The ACA also establishes a community health centers and National Health Service corps fund. The Fund will create an expanded and sustained national investment in community health centers which includes the integration of behavioral health and primary care.

3. Expanded access

The legislation provides across the board parity for mental health and substance abuse services. As insurance coverage is expanded, 95% of all Americans will have insurance to cover behavioral health services. The services will include preventive services such as tobacco cessation. The common practice of denying coverage for pre-existing conditions (such as depression, addiction, etc.) is prohibited. This provision applies immediately to persons who have been uninsured because of a pre-existing condition.

4. Workforce support

Improves access to and delivery of health care services to all individuals, with emphasis on low income, uninsured, underserved, minority, health disparity and rural populations by any number of mechanisms such as increasing the number of qualified healthcare workforce through expanded student loan repayment and training programs for licensed professionals and paraprofessionals.

5. Quality improvement and use of evidence-based practices

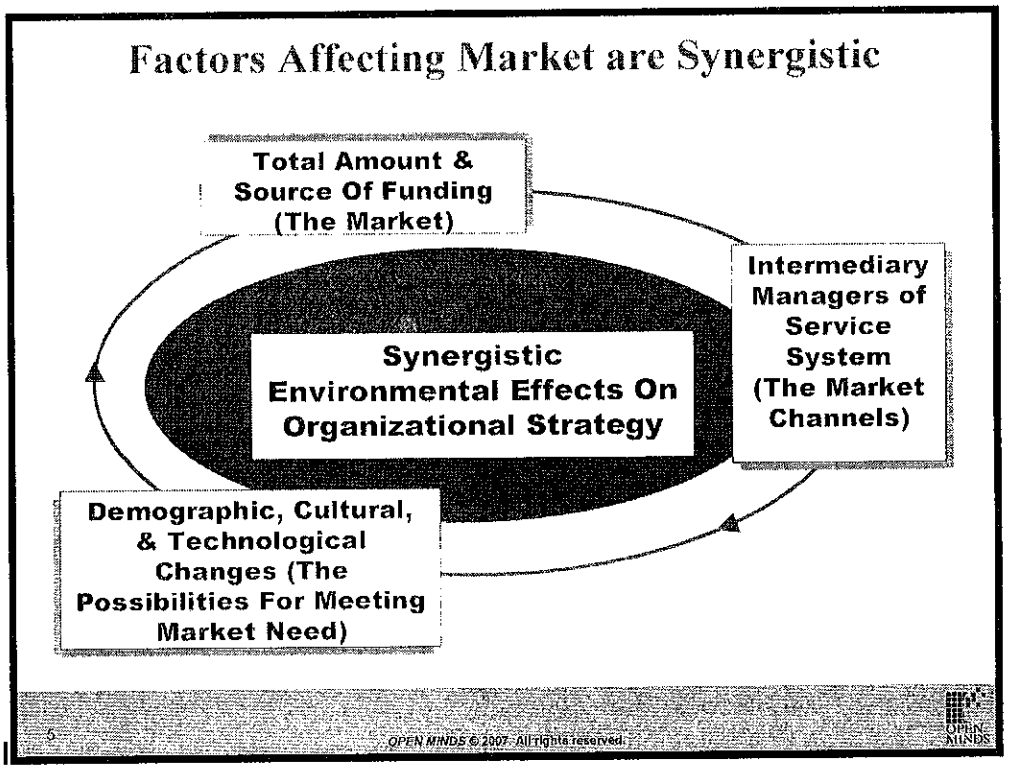
The Secretary of HHS is required to establish, submit and update annually a national strategy to improve the delivery of health care services, patient outcomes and population health. Once again MH/SA services are included.

The law also establishes a private, not for profit entity governed by a public-private sector board entitled the Patient-Centered Outcomes Research Institute tasked with indentifying priorities for and providing for conduct of comparative outcomes research. The Agency for Healthcare Research and Quality (AHRQ) is tasked to disseminate research findings of the Institute as well as other government-funded research to train researchers in comparative research methods and to build data capacity for comparative effectiveness research.

C. The Synergistic Effect of System Macroenvironmental Trends

The environmental changes reframing the long-term vision of payers, care management organizations, provider organizations, and professionals in the field are also creating an evolution in payer and consumer expectations and roles as expressed by system stakeholders. The result has been changes in where people with behavioral health and intellectual disorders/disabilities live and receive treatment. Payers "push" to integrate services and move financial risk to other stakeholders. Consumer preferences "pull" toward easy-to-use recovery-focused treatment and support services that are increasingly available and affordable with newly-created technologies. The strategic question becomes not "What do our customers need" but "What do our customers want?"

The intersection of the "push" of cost pressures and financing policy and "pull" of consumer preferences and technologies creates the pressure for new service system delivery models that are integrated, risk-based, and that deliver consumer-centric 'high-value' community-based care. Following is a graphic representation of the "push-pull" market factors for behavioral health providers.



As a result of these market factors, the characteristics of a successful behavioral health and social service delivery system stakeholder have changed. There are five key organizational characteristics and competencies that are likely to be required for success in this evolving marketplace:

- Ability to accept risk-based and/or performance-based payment (as preferred by the local payer)
- Integration with other service systems (as defined by the local market)
- Delivery of as much home-based and community-based service as technologically feasible and preferred by the customer
- Demonstration of a desired value proposition to consumers and payers in the local market
- Consumer-centric service focus

Each of these emerging critical competencies requires an enhanced understanding of the Cheaha marketplace. In particular, this environment requires an understanding of the degree of risk-based or performance-based contracting preferred by local payers – as well as preferred clinical models for integration and community-based service delivery. Cheaha's understanding of the market also requires data on the preference of consumers in Cheaha's target market – particularly with regard to service delivery characteristics. And, for both payer and consumer customers, Cheaha will need to

understand the 'value proposition' that distinguishes its services from the competitors and the metrics needed to document and demonstrate those services.

In this market, there appear to be four possible roles for Cheaha emerging:

- Destination-based services — centers of excellence with a reputation for excellent results where consumers will travel a distance for the specialized expertise and, in many cases, opt to stay "at home" to receive care instead of traveling out of the catchment area

- Specialty services with enhanced offerings for one-stop consumer shopping — specialty provider organizations that offer a broader array of services to meet more consumer health care and support needs at a single location, increasing both consumer convenience and service revenue

- Mobile and home-based services — specialty services delivered in the community in a wide array of locations, including but not limited to home care, school-based services, services in primary care clinics, and more

- Technology-enabled services — use of technology to deliver professional services by voice-only, e-mail-only, web-based, and remote video technologies

Further connection to these emerging roles and the strategic direction Cheaha can follow is discussed in Section VII.

IV. Alabama Trends in Health & Human Services

The future of Alabama's health and human services will be significantly influenced by three sets of factors: systemic issues including population demographics; public policies that drive allocation of resources and de-institutionalization; and, economic impacts of the current recession.

Alabama's population is estimated at just over 4.7 million people, representing a growth of 5.9% since the year 2000 – about half the rate of growth of the U.S. as a whole. Not surprisingly, the elderly make up an increasing percentage of the population with those over the age of 65 representing 13.8% of the total population or about 7% higher than the national average of 12.9%.

The poverty rate in Alabama is 20.45% higher than the U.S. rate. Statistics from the years prior to the current recession show that 15.9% of Alabama citizens lived below the poverty level. And finally, a significant factor impacting Alabama's health and human service system is the number of people with diagnosed disabilities. The rate of disability for individuals over the age of five is 20.08% in Alabama versus 16.2% across the country – a difference of almost 24%. For adults, alone, the rate is 16.1%, an increase of more than 33% above the national average.

These demographic characteristics can also be seen when comparing rates of insurance coverage within Alabama to those in other states. Despite its higher level of poverty, Alabama has a rate of uninsured citizens of only 14% compared to the national average of almost 17%. This gain, however, is tied directly to the level of aging in the population and the rate of disability. Medicaid provides health insurance coverage to over 20% of Alabama's citizens and Medicare covers another eighteen percent (18%).[ii]

While the rates of public insurance are relatively high, Medicare and Medicaid recipients do not receive a level of benefit that is consistent with those in other states, particularly in the arena of behavioral health and human services. Medicare benefits are tied directly to the qualifications of the provider. Most of Alabama is designated as a Medically Underserved Area and while the level of mental health providers exceeds that of primary care providers as determined by the Health Resource and Services Administration, Medicare requires a level of clinician credentials that is typically not available to Medicare recipients.[iii] Within the state's Medicaid Program, adults receive only 7.5% of the program's benefits as compared to 12.4% nationally. And, those with disabilities also receive disproportionately lower benefit level accounting for only 36.9% of system expenditures as compared to 42.4%, nationally.[iv]

Alabama has prioritized services to the most disabled within its public policy agenda over several years. Driven by a combination of consumer advocacy, lawsuits, contemporary service practice and economics, Alabama continues to move toward greater levels of community-based services and reductions in institutional care. Specific programs and projects have targeted individuals with Intellectual Disabilities as well as those with Severe and persistent mental Illness. Medicaid waivers and State grants/

contracts are utilized to support de-institutional efforts on a regional basis and to create community-capacity to divert future admissions to state institutions.

While Alabama's unemployment rate has been consistently lower than the national rate, the financial impact of the recession has been significant. In addition, Alabama has had to deal with losses of sales tax and income tax revenue related to the BP oil spill, further exacerbating a precarious budget situation. During each of the past four years, Alabama has had to close a significant deficit as a part of its budgeting process. Through the current fiscal year ending September 30, 2011 Alabama has relied heavily on cuts to education and receipt of federal stimulus funding through ARRA – the American Reinvestment and Recovery Act of 2009. In particular, Alabama's Medicaid Agency received $850 Million through an increase in the Federal Medical Assistance Percentage – the share of state Medicaid benefit costs paid by the federal government. Using this funding mechanism, Alabama preserved funding for most of its mental illness, substance abuse and intellectual disabilities services.

Unfortunately, that funding stream has expired and the economic recovery has not taken hold sufficiently to generate tax revenues high enough to sustain current levels of spending. While Alabama's current budget is balanced through September 2011, Alabama is anticipating a significant budget shortfall for FY 2012. The state is considering the use of a budget management procedure known as "proration" to reduce the amount of money distributed to agency's supported by state government to levels that match available cash despite the fact that the amounts may be lower than approved in the budget. Proration has been applied to some state agencies during each of the past several fiscal years. However, the loss of Medicaid FMAP support puts the Department of Mental Health and its contracting community partners at risk. While official statements have yet to be issued, informal discussions suggest that proration may result in as much as fifteen percent (15%) reductions during the remainder of the current FY 2011 and twenty-five percent (25%) for FY 2012.

Taken together with the macro-environmental factors previously discussed, it is clear that Cheaha Mental Health Center must make some strategic decisions that will both protect itself and its clients in the short-term and position it for future stability and growth.

Service Line Analysis

The concept of Service Line is intended to focus management attention on like services so as to leverage performance – both clinical and financial – across the organization. The service line analysis was designed to identify opportunities to improve performance, evaluate services that are underperforming and to highlight areas that can be improved. It is important that the use of service lines and their analyses be developed with the management team to maximize their benefits as management tools.

Cheaha supplied *OPEN MINDS* with a detailed service line financial report. The following analysis looks at each current service line and the total revenue and net income. *OPEN MINDS* concluded that these revenue items are the most appropriate aspect of the services line financials to review at this time, for several reasons. First, Cheaha has become masterful at controlling costs. While there are always process improvements and cost management techniques to pursue, it appears that these would be marginal except where dealing with the personnel costs attendant to excess hourly wages and overtime pay which result from management of the current time-off system. Second, audit adjustments – including depreciation costs - while a small percentage of overall expenses, have not been allocated to service lines. Given the small size of some cost centers and vastly fluctuating net income, the further allocation of these costs might significantly alter the financial picture of some service lines. Third, and most germane to this discussion, there is insufficient volume of service data that can be matched with cost information to allow an evaluation of cost per unit of service. That said, any other financial construct would simply substitute one set of program financial data for data for another without adding anything but analyst preference. To enhance the value of this analysis in the future, a reasonable attempt should be made to define units of service and to report both volumes of services and costs so as to permit this analysis.

The focus on revenue generation also takes center stage because, historically, community mental health centers have not made a successful transition from a grant-funded mentality to a fee-for-service environment. So, while productivity standards have been agonizingly designed and managed to entice clinicians, primarily in outpatient office settings, to approximate an expected value of work, the rest of the organization is left to fend for itself – generating revenue in excess of outpatient standards, feeling let down because they don't get a productivity bonus, but not knowing what a reasonable expectation for their service should be. Again, this is exacerbated by not having a unit of service costing system that is applicable across the organization. It should be noted that, while an automated system would be beneficial, it is possible to implement a workable hand-count system to jump start the process.

Table 1: Net Income By Disability Services								
Disability Services	FY 2009				FY 2010			
	Total Income	Total Expenses	Audit Adjustments	Net Income	Total Income	Total Expenses	Audit Adjustments	Net Income
Mental Illness	3,583,640.87	3,440,549.47		143,091.40	3,636,623.76	3,500,303.13		136,320.63
Intellectual Disabilities	2,929,319.74	2,424,785.56		504,534.18	2,644,069.50	2,452,849.73		191,219.77
Substance Abuse	1,260,320.89	1,162,706.22		97,614.67	1,311,718.03	1,250,117.48		61,600.55
Unallocated Administration	100,355.46	179,827.40	-493,307.69	-572,779.63	104,577.99	146,594.35	-204,935.24	-351,529.59
Total	**7,873,636.96**	**7,207,868.65**	**-493,307.69**	**172,460.62**	**7,696,989.28**	**7,349,864.69**	**-204,935.24**	**37,611.36**

Table 2: Net Income By Program			
Program	Net income		
	FY 2009	FY 2010	FY 2011*
Sylacauga Outpatient	-15,817.67	-71,715.13	-10,748.27
Syl Day Programs	108,490.09	139,838.29	32,734.18
Foster Care	12,559.17	7,883.02	18,281.43
MI CM			50,982.91
ALF	1,708.84	34,758.15	2,528.84
Community Living - Other	-36,949.26	575.39	-152.27
Total - Community Living	-35,240.42	35,333.54	2,376.57
Talladega Outpatient	-67,163.94	-94,864.79	-11,023.32
Randolph Outpatient	9,170.88	10,147.30	-13,996.25
Clay Outpatient	-9,578.03	-55,401.31	-22,536.06
Coosa Clinical Services	-30,287.40	1,683.76	
Sup. Housing			-385.52
PEER SUPP SPECIALIST	-8,339.12	17,853.91	-3,504.98
Hillwood - Other	142,152.72		
Total - Hillwood	133,813.60	-7,107.48	-28,534.35
IDP	3,086.86	-5,485.49	-1,975.900
C&A Inhome	6,132.56	-23,531.30	-22,310.97
Adult In Home	14,623.94	53,636.15	5,352.99
MI Services	-19,365.31	89,313.25	-11,266.08
Crisis Intervention	45,937.42	43,159.33	7,848.57
Juvenile Court Liason	-17,607.91	-891.39	5,169.59
Hooten	4,337.56	-3,531.03	818.01
EBP # 2			-4,114.30
Total - Mental Illness	143,091.40	136,320.63	-6,831.75
Burton Develop. Center	162,874.03	-17,911.35	-10,565.44

Table 2: Net Income By Program			
Program	Net income		
	FY 2009	FY 2010	FY 2011*
Cheaha Develop. Center	91,003.12	61,118.42	14,428.54
Personal Care	6,468.62	6,852.09	3,289.76
Main Avenue	-7,694.74	36,168.42	21,535.58
McKinney Learning Ctr.	-420.84	-21,990.72	3,900.29
Sunrise Apt			-5,926.68
College Street	-35,765.07	-22,400.11	2,715.45
EICM	25,334.98	3,255.05	
BDC Early Intervention - Other	28,454.89	8,535.01	8,237.79
Total - BDC Early Intervention	53,789.87	11,790.06	
Respite	-20.24		
ID Case Management	25,810.24	-15,709.84	518.43
Duplex	-25,653.47	-57,046.11	-23,575.34
Prater	-41,041.50	11,461.13	13,268.84
Cheaha Support. Employ.	21,954.81	42,503.40	13,629.71
ALP	254,394.46	197,918.98	22,108.93
OLA	-1,165.11	-2,012.95	210.19
EI Case Management		-1,146.62	-2,230.07
Intellectual Disabilities		-38,375.03	
Total – Intellectual Disabilities	504,534.18	191,219.77	61,545.98
Environment Prevention			2,825.93
Prevention Other			22,637.13
Prevention	22,640.26	36,393.57	25,436.06
DUI	15,165.21	15,811.95	3,401.40
Drug Court		12,685.26	2,740.04
Caradale		-3,293.23	15,946.51
Detox			-385.52
SA IOP			33,527.40
SA Ambulatory	59,809.20		
Total - Substance Abuse	97,614.67	61,600.55	80,692.89
Total Cheaha Mental Health Center	172,460.62	37,611.36	171,215.56
Unallocated Administration	-572,779.63	-351,529.59	35,808.44

* This data is through November 30, 2010

The commonality of purpose and function of the various outpatient clinics offers a clear opportunity to apply the Service Line concept. Data from Table 2 – Net Income by Program – show a consistent pattern of loss over the three years for which data was reviewed. The increasing challenge of balancing competing clinical priorities in mental illness outpatient settings – delivering appropriate services to the most seriously ill and high demand for sub-acute services - with the financial reality of sustained losses, offers an opportunity for a system-wide performance improvement project. The Mental Illness Outpatient Performance Improvement Project also provides an immediate focus for several strategic objectives. A full description of the project is included in Section VII.

V. SWOT Analysis

The SWOT analysis helped to identify some key threats and opportunities for Cheaha. Organizational strengths include the knowledge and quality of staff and a move to collaboration and integration of services. The weaknesses include long wait times to obtain services. Opportunities for Cheaha include the use of telemedicine to expand and integrate services and a more in depth view of operational processes to increase revenue and efficiencies. Environmental threats include the growth of the indigent population and consumer choice that may opt to seek services at competitive provider sites. In the section that follows, a summary of the organizational SWOT analysis and an analysis of the SWOT implications can be found.

- Strengths
    - Collectively, staff has a lot of knowledge
    - Positive Relationships with State and Communities
    - Long-Term Employees: Dedication, Values, Commitment
    - Financially Sound
    - Renewed Interest of the Board
    - Staff are Part of the Communities We Serve
    - Consumer Satisfaction: Positive for Intellectual Disabilities, Substance Abuse Services & Adult Mental Health Services
    - Employee Benefits
- Weaknesses
    - Mission unclear and outdated
    - Historically/now - we serve everyone – mental illness specific

- Lack of clinical Information System to measure & report effectiveness and efficiency
- Lack of Community knowledge about Cheaha
- Consumer Satisfaction for Child Mental Health Services
- 1970s Personnel Policies
- Performance Evaluations
- Lack of Productivity Measures & Rewards/Consequences
- Lack of automation resulting in excessive clinical and administrative paperwork

- Opportunities for improvement
  - Expansion of number of funding sources
    - Directly
    - Partnering
  - Increase Collaborations and Partnerships
  - Use of Clinical Technology
  - Expansion – Substance Abuse Services – Recovery Home
  - Expansion – Intellectual Disabilities – Residential Options

- Threats
  - State budget cuts – Reduction of Medicaid participation rate to pre-recovery levels
  - Competition from private sector providers – e.g. Bradford Health Services
  - Intellectual Disabilities – State control of the waiting list
  - Unemployment Rate
    - Increased demand for services
    - Higher demand for disability determination in lieu of employment
    - Decrease in private pay fees – especially Substance Abuse Services
  - Competition from Federally Qualified Health Centers

The following table summarizes the results of the SWOT Analysis. In the SWOT analysis there are areas for Cheaha identified as strengths, weakness, opportunities or threats. Each of these areas provides Cheaha with an opportunity to alter these strengths, weaknesses, opportunities, or threats to strengthen the organization.

- S-O Strategies pursue opportunities that are a good fit to Cheaha's strengths.
- W-O Strategies overcome weaknesses to pursue opportunities
- S-T Strategies identify ways that Cheaha can use its strengths to reduce vulnerability to external threats
- W-T Strategies establish a defensive plan to prevent Cheaha's weaknesses from making Cheaha susceptible to external threats

As the foundational Strategic Initiatives and Objectives are undertaken and achieved, this construct allows future actions to be matched, accordingly.

Table 3 :SWOT Analysis		
	Strengths Staff Knowledge Positive Relationships w/ State & Communities LT Employees: Dedication, Values, Commitment Employee Benefits Financially Sound Renewed Interest of Board Staff are Part of Communities We Serve Consumer Satisfaction except Child MH	**Weaknesses** Mission Unclear & Outdated Historically/now – We Serve Everyone – MI specific Lack of community knowledge about Cheaha Low Consumer Satisfaction – Child MH Lack of Clinical Info System to Measure & Report Effectiveness & Efficiency 1970s Personnel Policies Performance Evaluations Lack of Productivity Measures & Rewards/Consequences Lack of Automation Resulting in excessive paperwork
Opportunities Expansion of Number of Funding Sources **Directly** Partnering Increase Collaborations & Partnerships Use of Clinical Technology Expansion SA Services – Recovery Home Expansion ID Services – Residential Options	S-O Strategies	W-O Strategies
Threats State Budget Cuts – Medicaid Federal Participation rate Competition from Private Sector – i.e. Bradford Health Competition from FQHCs ID Services – State control of Waiting List Unemployment rate + demand for Services & Disability determinations Decrease in Private Pay Fee	S-T Strategies	W-T Strategies

VII. Strategic Direction

Cheaha's consideration of a revised mission - to become the preeminent human services organization for people with specialty healthcare needs - incorporates both preventive and maintenance approaches to support the consumer's overall health and to build resiliency and strength that sustain the consumer's well-being.

The following section is compiled of four chapters:

- Environmental Factors
- Strategic Initiatives
- Three Year Plan
- Implementation Project – MI Outpatient Performance Plan

A. Environmental Factors

Cheaha is a traditional community mental health center focused on the provision of services to individuals with mental health, addictions, and intellectual disabilities; primarily funded through the Alabama State contract for Services and Medicaid. In viewing how to move Cheaha in a new strategic direction, it will mean shifting Cheaha's focus from a payer source to a population source. Making Cheaha's focus shift from payers to a consumer centric provider of service will enhance Cheaha's position in the changing market where the consumer is the selector of service provider.

Cheaha Future System Evolution

This chart shows where Cheaha is today vs. the future scenarios that drive the strategic direction of the organization.

Table 4: Today vs. Future Scenarios

Future System Evolution	Current Services	Future Scenarios
Destination-based services	Current services rely on the consumer to come to Cheaha facilities	Future services will either bring Cheaha to the consumer or will create programs that populations not currently served will select
One-stop shopping	Does not exist	One stop shopping for facility based services
Mobile and home-based	Services exist but are labor and transportation intense	The expansion of service offerings to homes, schools, daycares and other service organizations
E-health	Does not exist	Expertise expansion and mobile and home-based service expansion

Long term strategic planning requires a thorough assessment of environmental factors influencing market operations. Several questions must be answered in order to frame consideration of longer term objectives:

- What trends are influencing the market at this time?
- Who are our customers and what do they want?
- What other organizations are competing for our customers?
- How much are customers willing to pay for services?

What trends are influencing the market at this time? The two largest trends influencing the market are e-health capabilities and consumer choice. These trends are interactive, in terms of how e-health will contribute to customer choice. Alabama has certainly been a leader in initiating programs to provide consumer options. The need for expansion into rural Alabama markets is augmented through the initiation of e-health technologies without the burden of adding additional staff. In fact, it is our belief that some case management field staff can be reduced and the existing supervisory staff with more program expertise can become the e-health experts to these remote locations. The consumer experience begins with marketing and ends with service. Improving both aspects of this experience will ensure Cheaha's ongoing success.

- Who are our customers and what do they want? Cheaha's customer base has expanded from the patients Cheaha serves to the patients Cheaha does not serve, but could. The revision of the Cheaha consumer experience from intake to service will enhance an untapped market of private-pay patients and those who might otherwise shy away from seeking service in a community mental health setting. The advent of ongoing community collaborative efforts dictates that Cheaha take a structured approach to new business development and new program expansion and implementation. The collaborative agencies want assurance that not only is Cheaha a partner, but can take a lead role and implement programs once designed.

- What other organizations are competing for our customers? For most of Cheaha's current client base, there is not a major competitor. No other providers are interested in subsidizing care, nor in developing the expertise and comprehensive systems of care to meet the complex needs of Cheaha's major client groups. As more consumers become covered by private health insurance or Medicaid, the competition may change. Additionally, creating programs to serve the emerging needs identified in the Alabama trends section may allow Cheaha to compete against other community mental health centers who may not offer the programs that are coming to market.

- How much are customers willing to pay for services? The customer landscape is changing rapidly. Previously, it was the government payer or an intermediary who was seen as the customer. These payers will be looking for providers to meet their target requirements in order to avoid incurring financial performance penalties.

The answer to these questions leads to five summary trends influencing Cheaha's market position. The trends are as follows:

- State and federal changes to the Medicaid program
- Emerging technologies
- Payer preference for "integrated" services
- Growing role of consumer preference and choice
- Changing market role for specialty service providers

The objectives selected for the strategic plan allow Cheaha to create a market position that will leverage emerging technologies to expand its market position, allow Cheaha to leverage additional payer sources while meeting the strategies set forth by Medicaid and Medicare, and to develop services that consumers will select as the specialty provider of choice.

OPEN MINDS has highlighted the emergence of consumer choice throughout this report. Driving some of these choices may be new or existing court-ordered parenting and addiction programs. As poverty levels continue to increase —increasing the pool of eligible consumers — a growing number of consumers will make their service selection based on convenience, rapid access to care, and the sense of privacy and consistency of the treatment experience. The integration of medical and behavioral services and service offerings unique to specific populations (child/geriatric) where consumers can receive most of their health care needs met will position Cheaha in a unique market position.

B. Strategic Initiatives

OPEN MINDS and the Cheaha leadership identified seven overarching key strategic initiatives to bolster its operating foundation and provide a platform for future growth and development. Based on our internal and external stakeholder review; the trends in consumer choice; changes to funding mechanisms allowing consumer choice; and, questions about the appropriateness or capacity of Cheaha services to efficiently and effectively meet the needs of everyone who requests services, the strategic initiatives include:

- Leadership Initiative (#1): To exercise accountable leadership through engaged governance and best management practices.
- Workforce Development Initiative (#2): To strengthen and enhance the workforce as a primary means to achieve quality services and organizational performance.

- Quality Initiative (#3): To improve the quality of clinical services and administrative functions through the systematic measurement of performance with a focus on future results.

- Clinical Services & Supports initiative (#4): To improve and expand the continuum of clinical services and supports that are self-financed and generate an operating margin.

- Technology Initiative (#5): To enhance clinical, support and administrative practice through acquisition and effective application of technology.

- Finance Initiative (#6): To assure financial viability and promote the growth of the organization.

- Communication Initiative (#7): To actively communicate the Vision, Mission, Core Values and Performance Outcomes of the organization.

C. Three -Year Plan

After considering the key objectives required to achieve Cheaha's seven strategic initiatives, a high-level work plan has been developed. Given the foundation building nature of many objectives, greater emphasis has been placed on the first year of implementation.

- Leadership Initiative (#1): To exercise accountable leadership through engaged governance and best management practices.

    - Calendar Year 2011

        - Review, validate and/or update the Vision, Mission and Core Values of the organization in the context of the strategic imperatives driving this planning process

            - Use MI Outpatient Clinics as a focus to evaluate the efficacy of the draft Vision, Mission and Core Value statements

            - Refine the draft statements for Board consideration

        - Establish organizational performance expectations and metrics

            - Educate the Board and management regarding the Balanced Scorecard approach to performance management and improvement

            - Establish and communicate performance standards for MI Outpatient Clinics across the domains of clinical service, quality, satisfaction and financial viability

- Establish performance standards for the Key Objectives under Clinical Services and Supports Initiative
- Draft potential organization-wide performance standards

- Monitor and evaluate organizational performance on a continuing basis
  - Develop performance measurement tools and systems for MI Outpatient Clinics
  - Develop and implement performance management reports for MI Outpatient Clinics
  - Develop and implement performance management reports for Key Objectives under Clinical Services and Supports Initiative

- Incorporate evaluative results into a cycle of annual planning and performance improvement
  - Establish a performance review process for MI Outpatient Clinics
  - Incorporate MI Outpatient Clinics performance improvement plans into the annual budget and annual quality plan
  - Incorporate performance results and improvement plans for Key Objectives under Clinical Services and Supports Initiative into FY2012 budget and performance improvement plan

- Prioritize strategic initiatives and allocate resources accordingly

o Calendar Year 2012

- Review, validate and/or update the Vision, Mission and Core Values of the organization in the context of the strategic imperatives driving this planning process
  - Adopt updated Vision, Mission and Core Value Statements

- Establish organizational performance expectations and metrics
  - Establish and communicate performance standards for one-third of all MI, SA and ID programs across the domains of clinical service, quality, satisfaction and financial viability
  - Adopt and implement organization-wide performance standards in at least two of the following domains: clinical

services / administrative processes; quality; satisfaction; or financial viability

- Monitor and evaluate organizational performance on a continuing basis
  - Develop performance measurement tools and systems for one-third of all MI, SA and ID programs
  - Develop and implement performance management reports for one-third of all MI, SA and ID programs
  - Develop performance measurement tools and systems for organization-wide performance measurement in at least two of the following domains: clinical services / administrative processes; quality; satisfaction; or financial viability
- Incorporate evaluative results into a cycle of annual planning and performance improvement
  - Establish a performance review process for one-third of all MI, SA and ID programs
  - Incorporate performance improvement plans for one-third of all MI, SA and ID programs into the annual budget and annual quality plans
- Prioritize strategic initiatives and allocate resources accordingly

o Calendar Year 2013

- Establish organizational performance expectations and metrics
  - Establish and communicate performance standards for all MI, SA and ID programs across the domains of clinical service, quality, satisfaction and financial viability
  - Adopt and implement organization-wide performance measures across all of the following domains: clinical services / administrative processes; quality; satisfaction; and financial viability
- Monitor and evaluate organizational performance on a continuing basis
  - Develop performance measurement tools and systems for all MI, SA and ID programs
  - Develop and implement performance management reports for one-third of all MI, SA and ID programs

- Develop performance measurement tools and systems for organization-wide performance measures across all of the following domains: clinical services / administrative processes; quality; satisfaction; and financial viability

- Incorporate evaluative results into a cycle of annual planning and performance improvement

  - Establish a performance review process for all MI, SA and ID programs

  - Incorporate performance improvement plans for all MI, SA and ID programs into the annual budget and annual quality plan

- Workforce Development Initiative (#2): To strengthen and enhance the workforce as a primary means to achieve quality services and organizational performance.

  - Calendar Year 2011

    - Develop an employee performance plan that links current position descriptions, performance expectations and evaluations

      - Review and update position descriptions, performance expectations and evaluation instruments and processes for MI Outpatient Clinics

    - Assess staff development needs for both current and future skills and implement appropriate training, education and interventions

    - Revise time-off policies to balance the value of legitimate needs of employees with the financial implications for current operations and long-term financial stability

    - Update personnel policies to reflect current Cheaha operations and contemporary human capital management approaches

      - Review and update personnel policies necessary to support performance improvement plans for MI Outpatient Clinics and assure applicability across agency

    - Upgrade recruitment and retention standards to assure that employees and contractors have the education, training, licensure and experience necessary to meet Cheaha's service and financial requirements

- Review and update recruitment and retentions standards for MI Outpatient Clinics to support performance expectations and performance improvement plans.

- Calendar Year 2012

  - Develop an employee performance plan that links current position descriptions, performance expectations and evaluations with performance-based pay

    - Review and update position descriptions, performance expectations and evaluation instruments and processes for one-third of all MI, SA, ID programs and Administrative services

    - Research and evaluate performance-based pay plans that support individual and program performance expectations for MI Outpatient Clinics and assess applicability to all MI, SA, ID programs and Administrative services

  - Create a manpower plan that matches staffing levels of appropriately trained/credentialed staff with the nature and volume of work and program services based on industry manpower standards

  - Update personnel policies to reflect current Cheaha operations and contemporary human capital management approaches

    - Review and update personnel policies necessary to support performance improvement plans for at least one-third of all programs and departments and assure applicability across agency

  - Evaluate the currency, competitiveness and cost-benefit of the employee compensation plan including both pay and benefits.

- Calendar Year 2013

  - Develop an employee performance plan that links current position descriptions, performance expectations and evaluations with performance-based pay

    - Review and update position descriptions, performance expectations and evaluation instruments and processes for all MI, SA, ID programs and Administrative services

    - Research and evaluate performance-based pay plans that support individual and program performance expectations for all MI, SA, ID programs and Administrative services and assess applicability across all programs and departments

- Update personnel policies to reflect current Cheaha operations and contemporary human capital management approaches

    - Review and update personnel policies necessary to support performance improvement plans for all programs and departments and assure applicability across agency

- Quality Initiative (#3): To improve the quality of clinical services and administrative functions through the systematic measurement of performance with a focus on future results.

    - Calendar Year 2011

        - Evaluate the efficiency and effectiveness of clinical services and administrative activities

            - Define efficiency and effectiveness for MI Outpatient Clinics and incorporate minimum expectations into the performance management plan

            - Develop and implement performance monitoring systems and management reports for all efficiency and effectiveness standards for MI Outpatient Clinics

        - Identify potential evidence-based and emerging best practices

            - Review current practice demographics, presenting problems and diagnoses in MI Outpatient Clinics and identify potential evidence-based and emerging best practices consistent with draft Vision, Mission, Core Values and performance standards

        - Measure consumer, family, staff and payer satisfaction

            - Review the results of consumer, family and staff strategic planning surveys to identify issues affecting satisfaction for MI Outpatient Clinics. Incorporate these conclusions into program and administrative service performance management and improvement plans

- Calendar Year 2012

  - Evaluate the efficiency and effectiveness of clinical services and administrative activities

    - Define efficiency and effectiveness for one-third of all MI, SA and ID programs and incorporate minimum expectations into the performance management plan

    - Define efficiency and effectiveness for all Administrative services and incorporate minimum expectations into the performance management plan

  - Identify and implement evidence-based and emerging best practices

    - Select evidence-based or emerging best practices for MI Outpatient Clinics and provide training and education for staff, consumers and families in preparation for implementation

    - Implement selected evidence-based and emerging best practices within MI Outpatient Clinics

    - Review current practice demographics in one-third of all MI, SA and ID programs and identify potential evidence-based and emerging best practices consistent with Vision, Mission, Core Values and performance standards

    - Select evidence-based or emerging best practices for one-third of all MI, SA and ID programs and identify training and education for staff, consumers and families in preparation for implementation

    - Review of professional literature for Administrative services to identify best practices for at least one-third of current business processes

  - Establish and monitor outcome expectations

    - Review and adopt outcome measures for selected evidence-based and emerging best practices in MI Outpatient Clinics. Develop an implementation plan.

  - Measure consumer, family, staff and payer satisfaction

    - Review the results of consumer, family and staff strategic planning surveys to identify issues affecting satisfaction for all MI, SA and ID programs. Incorporate these conclusions into program and administrative service performance management and improvement plans

- Monitor consumer, family and staff satisfaction through required and agency adopted program and administrative service performance management and improvement plans

- Identify payers to be surveyed for satisfaction

- Calendar Year 2013

  - Evaluate the efficiency and effectiveness of clinical services and administrative activities

    - Define efficiency and effectiveness for all MI, SA and ID programs and incorporate minimum expectations into the performance management plan

  - Identify and implement evidence-based and emerging best practices

    - Provide required training and Implement selected evidence-based and emerging best practices within one-third of all MI, SA and ID programs

    - Review current practice demographics, presenting problems and diagnoses in all MI, SA and ID programs and identify potential evidence-based and emerging best practices consistent with draft Vision, Mission, Core Values and performance standards

    - Implement best practices for at least one-third of current business processes

    - Review and identify best practices for all current business practices

  - Establish and monitor outcome expectations

    - Review and compare current outcome measures in one-third of all MI, SA and ID programs with outcomes expected from selected evidence-based and emerging best practices. Develop an implementation plan for any changes.

  - Measure consumer, family, staff and payer satisfaction

    - Monitor consumer, family and staff satisfaction through required and agency-adopted program and administrative service performance management and improvement plans

    - Develop and administer a payer satisfaction survey and incorporate the results into the performance management plan

  - Explore accreditation at both the program and organization levels

- Clinical Services & Supports initiative (#4): To improve and expand the continuum of clinical services and supports that are self-financed and generate an operating margin. After assuring that required services are provided, new services and programs will be pursued that draw on organizational competencies and have an acceptable return on investment. Initially, the following service improvements or expansions have been identified:
    - Calendar Year 2011
        - Intellectual Disabilities Services
            - Develop apartment-based residential living in Talladega
            - Develop respite service in Talladega – private pay market
        - Mental Illness Services
            - Increase basic living skills
            - Develop and implement mobile therapist model
            - Increase case management
            - Increase the use of group therapy
            - Pursue primary care integration opportunities
            - Expand and improve child and adolescent services
        - Substance Abuse Services
            - Improve occupancy rate for residential services
            - Explore recovery home residential model
            - Improve Drug Court use of treatment services to achieve break-even
    - Calendar Year 2012
        - Incorporate Calendar Year 2011 results from Key Objectives into FY 2012 Annual Budget and Performance Improvement Plan
        - Identify and implement self-financed clinical services and support expansions and/or enhancements that also generate an approved margin

- Calendar Year 2013
  - Incorporate Calendar Year 2012 results from Key Objectives into FY 2013 Annual Budget and Performance Improvement Plan
  - Identify and implement self-financed clinical services and support expansions and/or enhancements that also generate an approved margin

- Technology Initiative (#5): To enhance clinical, support and administrative practice through acquisition and effective application of technology.
  - Calendar Year 2012
    - Develop a technology plan that addresses clinical needs for telehealth, on-line and computer-based services and on-line support groups; management needs for an integrated electronic health record and billing system; and, technology security and development
  - Calendar Year 2013

    Prioritize technology developments and coordinate funding of acquisition with then current federal/state initiatives and self-funded resources

- Finance Initiative (#6): To assure financial viability and promote the growth of the organization.
  - FY 2011
    - Accumulate 3 months operating cash
      - Accumulate up to $1.7 M cash reserves beyond operating needs in accordance with FY 2011 budget
    - Establish clear performance metrics for efficiency and effectiveness
      - Define and communicate financial performance standards for MI Outpatient Clinics including measures of efficiency and effectiveness
      - Accumulate and evaluate the efficacy of existing financial performance measures across all programs and departments

- Review existing organization-wide performance measures in light of Strategic initiatives and Key Objectives

- Identify needed timely management reports to support strategic and operating goals
- Maximize rental income from center properties
- Reduce/contain support expenses

o FY 2012

- Accumulate 3 months operating cash
  - Accumulate up to $2.0 M cash reserves beyond operating needs in accordance with FY 2012 budget
- Establish clear performance metrics for efficiency and effectiveness
  - Define and communicate financial performance standards for one-third of all MI, SA and ID programs including measures of efficiency and effectiveness
  - Develop and implement organization-wide performance measures in light of Strategic initiatives and Key Objectives
- Develop and implement timely management reports to support strategic and operating goals
- Maximize rental income from center properties
- Reduce/contain support expenses

o FY 2013

- Accumulate 3 months operating cash
  - Accumulate up to $2.3 M cash reserves beyond operating needs in accordance with FY 2013 budget
- Establish clear performance metrics for efficiency and effectiveness
  - Define and communicate financial performance standards for all MI, SA and ID programs including measures of efficiency and effectiveness
- Develop and implement timely management reports to support strategic and operating goals

- Maximize rental income from center properties
- Reduce/contain support expenses

- Communication Initiative (#7): To actively communicate the Vision, Mission, Core Values, Plans and Performance Outcomes of the organization to its stakeholders including consumers & families, staff, local governments, allied health and human service organizations, communities and citizens-at-large

  - Calendar Year 2011

    - Sustain outreach and engagement activities including active dialogue through planned visits with public officials and other community leaders
    - Develop Cheaha's website to provide timely and accurate information about services and to educate the public regarding current behavioral health and disabilities issues of national, state and local interest
    - Develop Cheaha's intranet to facilitate communication with staff regarding a range of issues including this Strategic Plan, its Initiatives and Objectives
    - Assess consumer and family needs for clinical and peer support information and implement a plan to respond using a multi-media channels including brochures, videologs via the flat screen TVs in waiting rooms and public forums such as libraries
    - Establish Cheaha's professional staff as community experts on behavioral health and disabilities issues by responding to requests for speakers and promoting their availability to address community and civic groups.
    - Educate agency staff, allied health and human service organizations and interested citizens about Mental Health First Aid
    - Develop a Communication Plan for Calendar Years 2012 – 2013

D. Implementation Project – MI Outpatient Performance Plan

The focus of these Strategic Initiatives and Objectives is to build a foundation from which Cheaha can secure its viability and pursue future growth. The organization finds itself needing to address most of these Initiatives and Objectives across the entire organization, simultaneously. The concurrent demands on management and other human resources will be very high. And, the majority of the financial resources necessary to implement this Strategic Plan must be generated from within.

With these realities in mind, Cheaha will undertake an implementation project during Calendar Year 2011. By focusing the implementation of strategic initiatives and objectives around improving the performance of a specific service line, Cheaha will create a learning laboratory that allows it to: build the organizational capacity to undertake strategic development; incorporate best clinical and administrative practices into ongoing operations; create a culture of performance throughout the organization; achieve results that have immediate impact; and "learn by doing." The implementation project will focus on performance improvement for Cheaha's MI Outpatient Services.

This service line was selected as the focus of a strategic plan implementation project for a number of reasons. First, these programs have experienced burgeoning demand as the economic recession heightened and has held on tenaciously with unparalleled high levels of unemployment. Second, the demand for services comes from a sector of consumers and families who generally do not meet the State of Alabama's criteria to be served using contract resources, nor do they qualify for Medicaid. Third, these programs represent the vanguard of potential future development. Fourth, the size and scope of these programs encompasses 25 – 30% of the Cheaha workforce. And, finally, these programs have consistently produced financial operating losses - $83,387 in FY 2009, $140,119 in FY 2010 and $58,303 through November, 2010, just 2 months into FY 2011.

The implementation project will focus on improving the performance of these programs using an applied research model. Each Strategic Initiative and Key Objective will be incorporated into a performance improvement plan with specific, measurable expectations described. As implementation activities are undertaken, a continuous review of the actual results and unanticipated obstacles will be shared with management and staff. The problem-solving that occurs will result in appropriate modifications to the performance improvement process and will inform the organization about how to apply these strategic initiatives and key objectives in other parts of the organization.

VIII. Required Resources for Key Strategic Initiatives

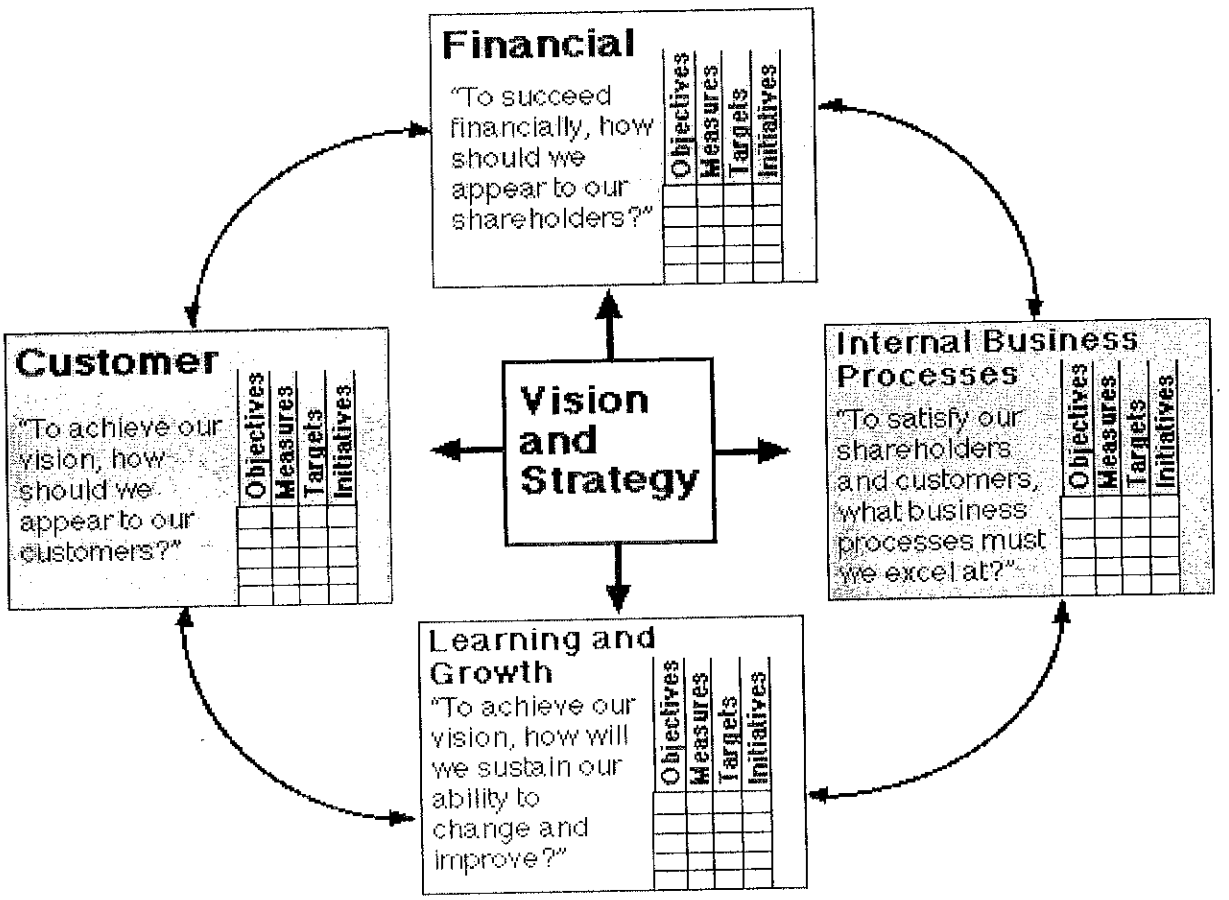
The required resources to meet some of Cheaha's key strategic initiatives do not currently exist within Cheaha. Historic commitments to clients and communities, sometimes burdensome compensation requirements, the economic downturn and its impact on both upward demand for services and fewer resources with which to meet that demand and some perennially under-performing clinical programs have combined to stretch the financial resources of Cheaha to an uncomfortable level. For that reason, the Executive recommended and the Board approved a financial plan under which net income in excess of that required to fund operations and contribute to the accumulation of 3 months operating cash reserve will be set aside for strategic developments. Once accumulated, the use of funds will be prioritized in support of specified strategic initiatives and specific objectives.

The review of corporate vision, mission and values will be significant in re-aligning service developments and re-establishing client, family, staff and community expectations such that resources—both human and financial—can be appropriately aligned.

Appendix A: Performance Improvement Model – Balanced Score Card

Background:

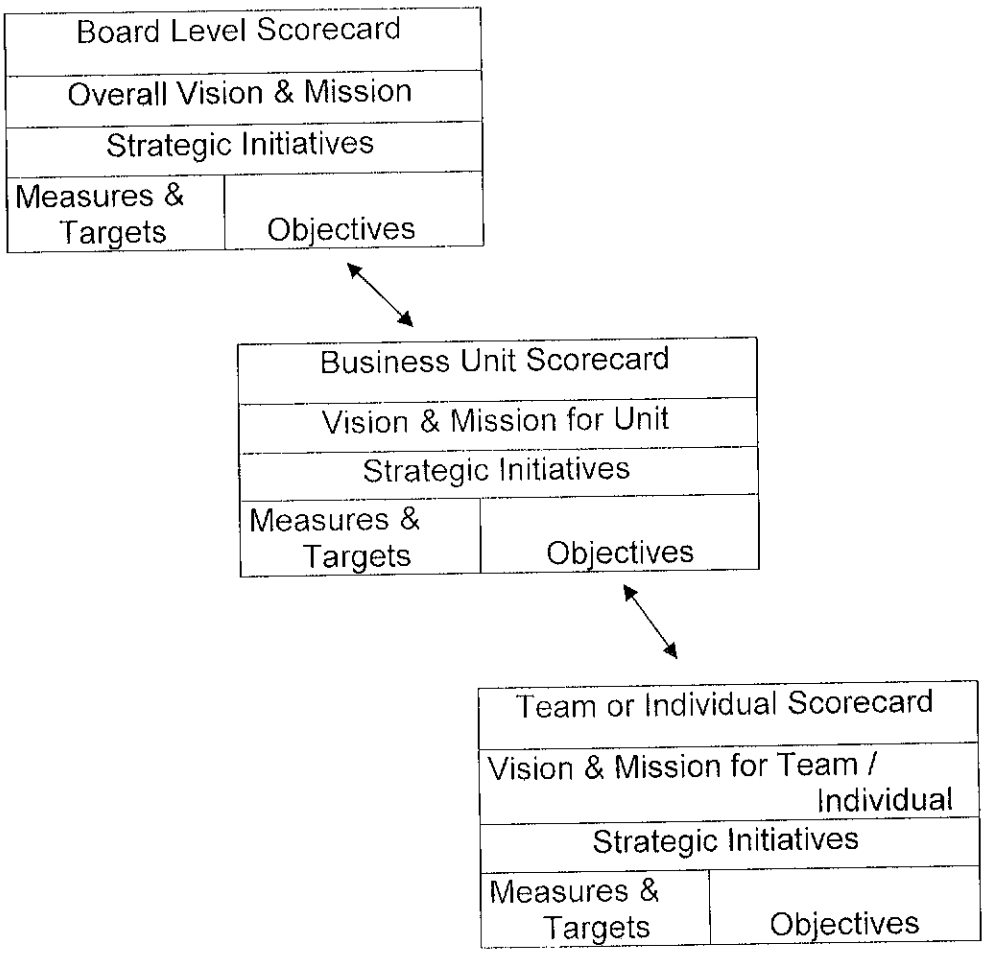
The Balanced Score Card originated in 1990 from a one-year, multi-company study of private sector companies conducted by Kaplan and Norton. The study concluded that even in for-profit organizations, reliance on financial measures alone was insufficient for managing complex and ever-changing business environments. The scorecard sought to remedy this by providing a more balanced suite of performance measures across a number of key perspectives. Typically these look at customers, finances, internal processes and organizational learning. However they can be adapted depending on what factors are considered important for the success of the particular organization.



During the next decade, the Balanced Score Card (BSC) evolved from an improved performance measurement tool to a strategic management system. Senior executives used the BSC as a central organizing framework to formulate, communicate, and execute strategy and to learn and adapt their strategy to changing conditions.[v] By the early 2000's, several innovative healthcare executives had adapted the use of the BSC to help their organizations balance the complex trade-offs among cost, quality, access and consumer choice.69

Having begun as a performance measurement tool, the Balanced Scorecard was quickly being used as a multi-dimensional framework for managing strategy by linking initiatives, objectives, targets and measures across key corporate perspectives.

Scope:
The Balanced Scorecard is a holistic model that can be used at various levels across the organization, service, team or group. It is used to manage strategy by linking initiatives to objectives, targets and measures across a range of corporate perspectives. These perspectives are determined by the organization using the model. The balanced scorecard can be used at various levels in an organization, simultaneously.



Many organizations now use a Balanced Scorecard to:

- formulate and refine strategies;
- communicate strategies and priorities throughout the organization;
- link strategic initiatives and objectives to long term targets and budgets;
- monitor progress and introduce initiatives to improve performance.

Key strengths of the model

- Holistic overview of organizational health
- Focuses individual objectives to the wider picture helping to create ownership, understanding and focus at all employee levels
- Links targets and measures to operational objectives and in doing so helps rationalize performance information, identify gaps and ensure balance
- Facilitates communication and understanding of business goals and strategies at all levels
- Encourages a focus on key priorities, assists in allocating resources and helps organizations / groups to become more results orientated[vi]

Issues in implementation:

Organizations should not be afraid to tailor the scorecard to be meaningful at a local level. Community-based, public sector services have more complex perspectives to consider than private sector organizations and there is a danger that organizations will merely massage existing measures into an "off the shelf" framework. The success of the approach is based on the organization having a clearly defined vision and strategic objectives. The scorecard can encourage a focus on existing short term goals rather than encouraging innovation and transformation. So, leaders must make efforts to ensure that staff do not see the scorecard as simply a measurement project.

Capacity and skills issues:

The balanced scorecard is relatively simple to implement if the organization has a clear vision, mission and strategies in place. It is not steeped in methodology and is easy to use at all levels. There are minimal resource implications for implementing the scorecard. Recent data from business intelligence reports suggest that implementation across the enterprise takes 4-6 months.[vii]

Appendix B: Integrated Care

Cheaha's interest in developing along a path integrating primary care and behavioral health care is consistent with changes in the overall market environment that require adjustments to meet the needs of cost containment and quality improvements. Increased integration of behavioral health and healthcare services is an emerging priority at the national, state, local, and consumer levels. Alabama has identified integration of primary and behavioral health care as a priority area under its mental health transformations initiative. Increasingly, and at all levels, care integration is seen as the most promising path to tempering expenditure growth and obtaining better value for health care spending. Equally importantly, capacity issues can also be addressed through integration of services, particularly in rural and underserved areas. What follows is a general discussion of current models for integrating primary and behavioral health care, some of the issues in adoption inherent to the process, and efforts underway in the state of Alabama.

The Need for Integration

Fragmentation in delivery of treatment for mental and physical illnesses is largely an artifact of how services have been funded. Mental health treatment has been largely state-funded and centered on state psychiatric facilities including provision of health, dental, and vision services. In the community, persons with serious mental illness (SMI) frequently have difficulty accessing health, dental, and vision services and often rely on emergency rooms (ERs) for their care. The results have been overwhelmed ER systems, discontinuous care for individuals, and exacerbation of polypharmacy issues. Failure to treat the whole person is increasingly acknowledged as a contributing factor in both the overall growth in healthcare expenditures and in poor health outcomes.

Incorporating behavioral health expertise into primary care is seen as critical to speeding initial treatment and to reducing the burdens and hazards of untreated mental disorders. Statistics validate the need for integration:

- Research indicates that people with serious mental illness die, on average, 25 years earlier than the general population.
- 60 % of premature deaths in persons with schizophrenia are attributed to medical conditions such as cardiovascular, pulmonary, and infectious disease
- Almost 70% of all health visits have a psychosocial basis
- 92% of all elderly patients receive mental health care from a primary care physician
- 50% of high healthcare consumers have mental health or chemical dependency disorders

- Only one in four patients referred to specialty mental health or chemical dependency treatment make the first appointment
- Closer integration of behavioral and primary care health services could save an estimated 20-30 % of total system costs[viii]
- Models for Integration
- Various models for integration of primary health (PH) and behavioral health (BH) have emerged. They share common features, but target different populations. Available models include:
- Primary Care Embedded in a Mental Health Program
- Unified Primary Care and Mental Health Program
- Co-Location of Mental Health Specialists within Primary Care
- Medical Home

Each of these models and an example of a successful implementation of the model follow:

Options for Primary Care/Behavioral Health Integration Models[ix]	
Model	**Example**
Primary Care Embedded in a Mental Health Program	EXCEL Group, Arizona: A nonprofit Medicaid health plan providing services to adults and children with serious mental illnesses. EXCEL Group has a small primary care clinic staffed by a family practice physician, physician assistant, nurse practitioner, and medical assistants, located within a behavioral health service clinic. Primary care services are provided to individuals receiving outpatient mental health services, with approximately 50 patients seen each day for physical care; the medical staff also conducts daily rounds at an adult inpatient psychiatric facility and a children's residential treatment center.
Unified Primary Care and Mental Health Program	Cherokee Health System, East Tennessee: A nonprofit organization which operates both a community mental health center and a federally qualified health center (FQHC). Cherokee Health Systems created its first integrated primary care and behavioral health clinic in 1984 and now provides integrated services in 21 sites and serves approximately 40,000 individuals annually. Full ranges of both primary care and mental health services are provided, including day programs, case management, and substance abuse treatment.

Options for Primary Care/Behavioral Health Integration Models[ix]	
Model	**Example**
Co-Location of Mental Health Specialists within Primary Care	Hackley Community Care Center, Michigan: Hackley Community Care Center is a FQHC with a staff that includes a social worker who assesses individuals' mental health, provides brief interventions for those with less serious problems, and refers those with serious mental illness to community mental health centers.
Medical Home	Vermont Medical Home Project: Vermont's Medicaid program received a grant from the Robert Wood Johnson Foundation for a three-year demonstration project designed to improve the physical health needs of adults with serious and persistent mental illness. In three counties, primary care nurses were placed in community mental health centers, where they performed health assessments, made connections with primary care providers, and served as members of the community mental health centers' treatment teams. The focus of the pilot was primarily consumers who were diagnosed with Type II diabetes. The nurses also helped consumers implement nutrition and exercise programs as part of their recovery self-management plans. After three years, data indicated that consumers who participated in the "Medical Home" project were able to significantly improve their health status and control care costs.

A. Model 1: Primary Care Embedded in a Mental Health Program

Advantages of embedding primary care in a mental health program include:

- Particularly appropriate for adults with serious mental illnesses, whose primary contact with the health system is through a mental health provider
- Diagnosis and treatment of previously unreported but significant illnesses increases
- Creates opportunities for regular screening, health education, and preventive services; consumers less likely to use emergency rooms and crisis-oriented health services
- Suitable for rehabilitation or day treatment programs where emphasis on recovery and self-management skills; within an outpatient mental health clinic program; or as a satellite primary care clinic within an existing mental health agency
- Strong working relationships develop between primary care and mental health providers with both groups expanding their knowledge and skills through reciprocal consultation, common training, and continuing education
- Use of integrated electronic medical records can facilitate communication and treatment planning. Client confidentiality and informed consent is for exchange of information between programs instead of between agencies

- Improves access to care, including preventive health care for problems that are common among persons with SMI (for example, diabetes treatment)

Challenges to embedding primary care in mental health include:

- Primary care staff is small and available for limited hours
- Funding challenges may require sources of support beyond third party reimbursement for direct services.

B. Model 2: Unified Primary Care and Mental Health Programs Through One Administrative Entity

Advantages of unified care through one administrative entity include:

- Integration goes beyond delivery of care to include administration and financing
- Addresses barriers to provision of time and resources for collaboration between primary care and behavioral health providers
- Provider collaboration, based on unified treatment planning, becomes possible
- Preventive care programs easily incorporated
- Single/shared medical records mean that providers do not have to duplicate health histories or depend on patient recall to learn about treatment plans

Challenges faced in establishing unified care through one administrative entity include:

- Difficult to move from small scale demonstration projects to larger scale efforts
- Primary care and behavioral health care providers need to work across disciplinary boundaries and these are skills sets that can prove challenging

C. Model 3: Co-Location of Mental Health Specialists within Primary Care

Advantages of co-location of mental health specialists within primary care include:

- Best used for integration of services to consumers with mild to moderate mental illnesses, who are seen mostly in primary care settings
- Increases access to mental health services to less seriously ill, can resolve symptoms, and raise consumer satisfaction
- Patients with serious physical illnesses often have co-occurring depression or other mild to moderate mental health problems.

- Access to crisis evaluations/screenings is increased by having behavioral care services available at the primary care site

Challenges of co-location of mental health specialists within primary care include:

- Role of co-located mental health professional and the time that will be required for evaluations, therapy, and consultation need to be explicitly defined
- If the co-located mental health professional is employed by an agency other than the primary care clinic, fiscal and information sharing problems may arise

D. Model 4: Medical Home Model

The advantages of creation of a medical home model of integration include:

- Patient-centered
- Responsibility for care and care coordination resides with the patient's personal medical provider working with a health care team
- Teams form according to patient needs and include specialists, midlevel providers, nurses, social workers, care managers, dietitians, pharmacists, physical and occupational therapists, family, and community
- Integrates needs of patients with multiple conditions
- Provide capacity for treatment of acute and chronic illness
- Focuses on prevention, care delivery, and coordination in a team environment
- Medicare and Medicaid funding for outcomes and care management
- Disadvantages of a medical home model include:
- New tools and care delivery systems will need to be developed, particularly with regard to health information technology and patient screening and outcome assessments
- Programs might see improvements in process measures such as screening rates more quickly than desired changes in utilization rates, financial outcomes, and health outcomes

In September 2010, the Alabama Medicaid Agency presented "Moving the Medical Home Forward in Alabama" to the Alabama Primary Health Care Association. The presentation included recommendations from the Medical Home Work Group which was formed in January, 2010. The key recommendation was for Alabama to adopt the North Carolina Model as the umbrella structure for furthering and supporting medical homes in Alabama.

The North Carolina Model is built around a system of regional, non-profit organizations charged with

- Driving the quality of care/Improving outcomes
- Providing care coordination in the gaps
- Enhancing care integration
- Developing collaborative relationships with providers
- The non-profits are paid a PMPM fee from the state.
- The non-profits employ:
    - Local Medical Directors
    - Local Pharmacy Directors
    - Local Administrators
- Strategies Employed:
    - Collaboration among all provider types in a region
    - Medical management meetings
    - Non-punitive comparisons of providers
    - Analysis of prescribing habits/academic detailing
    - Readmissions initiatives
    - ER utilization initiatives
- Local solutions are found to local problems.
- Avoids too stringent medical home criteria, but is supportive of practices as they move along the medical home path.
- The model involves all parts of the delivery system.
- The networks are driven by data: utilization patterns, prescribing patterns, patient adherence, etc.

E. Considerations for Integrated Care

Integration of primary and behavioral care requires structural, financial, and technical accommodations in order to achieve clinical integration from the consumer's perspective. All care integration models operate along a continuum of levels of collaboration and organizationally can be characterized as:

- Separate systems with formal methods of referral between them
- Co-location of primary care and behavioral health
- Co-location with collaboration (shared case records)
- Primary care and behavioral medicine integrated as a care team

While physical proximity (structural integration) is an important feature of integrated systems, communication is the real key to coordinating care for all populations. The degree of integration achieved is positively correlated with the level of communication and collaboration required. Successfully achieving integration is limited by:

- Financial Barriers
- Organizational Barriers
- Technological Barriers
- Financial Barriers Financial barriers impeding successful integration of primary and behavioral health care primarily are exacerbated by the fact that many activities associated with integrated care — care management functions, consultations between providers, and telephone consultation with patients — are not reimbursable under typical fee-for-service care. Moreover, behavioral health carve-out programs, by their very nature, promote non-integrated care, specifically in cases where behavioral health carve-outs do not include or allow for payment of primary care providers or school-based providers in practitioner networks. Additional impediments include a lack of awareness of allowable payment mechanisms; confusion caused by multiple reimbursement mechanisms; payment for only a limited number of visits, and low reimbursement rates.

  Integrated care programs and insurance plans have employed a number of strategies to address financial barriers, including credentialing of providers; providing creative employment and contract structures for care managers; and adoption of pay for performance.

  The Agency for Healthcare Research and Quality (AHRQ) concluded in a November 2008 report that strategies to address financial barriers to integration of primary care and behavioral health care remain limited in scope. AHRQ found that integrated care can achieve positive outcomes, but that efforts to implement integrated care will

have to address financial barriers.[x] Unfortunately, the financial barriers cited remain beyond the ability of individual health care entities to remedy.

- Organizational Barriers Organizational barriers impeding successful integration of primary and behavioral health care include issues related to change and to the process of care. Resistance to change; new staff and new roles; and balancing competing demands are difficult to overcome. Cultural differences between these provider types have the potential to derail efforts to achieve full clinical integration of care.

An Overview of Some Cultural Differences in Safety Net Organizations[xi]	
Community Health Centers	**State Mental Health Agency**
• National System • Safety Net Provider • Need-Based Services • Population-Focused • Prevention Oriented • Lifespan Care • Gatekeeper • Open Access • Flexible Scheduling • Treatment Team • Symptom Focus • Generalist • Governed by Users	• State Defined • Medicaid Provider • Eligibility-Based Services • Case-Focused • Rehabilitation Oriented • Episodic Care • Specialty Service • Restricted Access • Rigid Scheduling • Solo Provider • Personality Focus • Specialist • Governed by Community Leaders

Integration of services will require explicit clarification of mission and roles between primary care providers and behavioral health care providers, including development of specific transfer of care protocols. Provider training and support will be essential and ongoing. The National Association of State Mental Health Program Directors cites the following characteristics of successfully integrated practices:

- Team approach
- Strong clinical and practice management leadership
- Informal knowledge exchange
- Effective use of mid-level practitioners
- A loyal base of consumers
- Ability to serve patients with complicated problems and diverse cultural and socioeconomic backgrounds.[xii]

System Requirements

Effective collaboration anywhere along the integration continuum requires technology integration. The six most common shared IT functions used in integrated systems are:

1. An Organization-Wide Master Patient Index And Clinical Data Repository
2. Central Financial And Business Office Applications
3. Patient Scheduling
4. "Value-Added" Physician Services
5. Decision-Support And Outcomes Applications
6. Management Service Organization (MSO) Services

- Organization-Wide Master Patient Index And Clinical Data Repository Electronic personal health records (ePHRs) allow users to securely collate information from a number of sources, including self-entered data and records provided by participating care providers and payers. Patients have the authority to grant access to these records. Popular assumptions to the contrary, developing an integrated delivery system (IDS) does not require complete integration and commonality of function among all information technology (IT) functions of the systems care delivery components. IT infrastructure that is needed for collaboration between integrated systems includes:

  - Providing staff and clinicians with access to an integrated view of data across the organization
  - Connectivity to all care delivery sites
  - High-speed networks including support of data, voice, images, and multimedia
  - Browser-based interfaces including access to the internet, intranets, and xtranets
  - Desktop productivity tools (e.g., e-mail and calendaring)

- Central Financial And Business Office Applications. To achieve economies of scale, an IDS can adopt a central business office strategy, which involves consolidating patient management and patient accounting, general accounting, materials management, and managed care contract administration. Full integration of all components of the central business office, however, is not yet possible. Many existing legacy systems cannot provide multi-organization capabilities, and new central business office products for multi-organization integration are not scheduled for release until 2000 or later. Also, many commercially available patient management and patient accounting systems cannot accommodate the administrative requirements of managed care contract administration. Some IDSs are turning to multi-industry vendors to meet their materials management and general accounting needs. Until improved technology can accommodate organization-wide central business office integration, therefore, IDSs will need to continue to rely on less-than-ideal multivendor solutions.

- Patient Scheduling. As an organization acquires new care delivery components, the ability to schedule patients across a continuum of care may become increasingly important. A stand-alone scheduling system can be installed short-term, if necessary, early in the integration process. An interim solution may be a system that gives the scheduling departments of the IDS's care delivery components mutual access to data, even though it lacks true integration. Ultimately, the IDS can implement a fully integrated system with a scheduling engine that supports combined, organization-wide operations.

- "Value-Added" Physician Services. Providing low-cost, value-added services such as Internet/intranet access, e-mail, knowledge bases, and clinical information to physicians is important for the success of an IDS. At a minimum, physicians should be provided with remote access to test results through a user-friendly interface such as a Web browser. Some physicians may need additional services, and academic environments and similar high-physician-utilization sites also may require services such as remote order entry access.

- Decision-Support And Outcomes Applications. Decision-support and outcomes applications currently available typically process only inpatient financial data. Most products lack clinical and ambulatory focus, are not multi-organization-capable, and require considerable manual effort to massage the data into meaningful output. Decision-support and outcomes products now being developed are expected to incorporate both internal financial and clinical data across the continuum of care, as well as external sources for comparative information. Using advanced technologies, such as data warehouse tools, these information stores can be fully exploited.

- Management Service Organization (MSO) Services. The MSO services provided by an IDS can include managed care contracting, practice management, and IT support services. MSOs can provide this support from a central office with a common set of products and services for physicians across the IDS. The intent is to provide this support as a means to ensure patient flow and physician commitment to the IDS. Many IDSs, however, are withdrawing from providing MSO services because they have not realized profits originally projected

  Federal efforts to clarify understanding of mental health reimbursement in primary care settings are underway. A February 2008 Substance Abuse and Mental Health Services Administration report titled, "New Report on the Mental Health Reimbursement," addresses barriers to financial reimbursement and specific codes to be used in billing Medicare and Medicaid. Codes are summarized in the table that follows.

F. Medicare & Medicaid Payment for Integrated Mental Health Services

- Medicare & Medicaid Payment for Integrated Mental Health Services[xiii]

Type of Code	Service Codes	Diagnosis Codes	Type of Practitioner Allowed to Bill Medicare	Type of Practitioner Allowed to Bill Medicaid
CPT Psychiatry Codes (Level I Current Procedural Terminology, maintained by AMA)	Initial Evaluation: 90801 Psychiatric therapeutic codes: 90802–90899. Use with ICD-9-CM Psychiatry diagnostic codes.	MH diagnosis as Primary. Use psychiatric service codes w/ ICD-9-CM Diagnostic Codes 290–319 to identify mental, psychoneurotic, and personality disorders.	Mental health specialists: physicians and non-physicians, such as certified clinical social workers (CSWs) licensed by the state and clinical psychologists, licensed by and subject to state criteria, operating within the scope of their practice as defined by the state.	Many states allow payment for these codes; check with individual State Medicaid Program. (In use in IN)
CPT Health Behavior Assessment and Intervention (HBAI) Level I CPT	96150–96155	Physical Diagnosis from ICD-9-CM as Primary Diagnosis.	Non-physician mental health practitioners, such as psychologists, licensed by the state and subject to state criteria. CSWs may not use.	Up to the State; many do not yet pay for these newer codes. (Effective Jan. 1, 2008, FQHCs and RHCs may use in IN)
CPT Evaluation and Management (E/M) Level I CPT	99201–99215 (Office) 99241–99255 (Consultation)	Physical or Psychiatric Diagnosis from ICD-9-CM as Primary.	Physicians and primary care extenders, such as nurse practitioners, clinical nurse specialists, and physician assistants, licensed by the state.	Many states allow payment for use of E/M service code in primary care, and report use of E/M with ICD-9-CM Psychiatric Diagnosis Codes 290–319; check with individual State Medicaid Program. (In use in IN)
Level II HCPCS ("State" Codes, used more often by Medicaid; maintained by CMS)	A-V codes are standardized nationally; G codes include some substance use codes; W-Z codes are state-specific.	Depends on service.	Medicare pays for some Level II codes, including A, G, J codes; Medicare does NOT pay for H (State mental health codes), S, or T codes. H codes are for Medicaid only. As of 2008, two new Medicare alcohol/drug assessment brief intervention "G" codes: G0396 and G0397.	Medicaid State agencies more often allow the Level II codes. The H and T codes are for Medicaid only. Check with individual State Medicaid Program.

Appendix C: Federal and State of Telehealth Rules for Medicare and Medicaid

Telehealth services are well-established in the disciplines of radiology and dermatology, and are being expanded into home telehealth, mental telehealth, ocular telehealth, teledermatology, telepathology, and telerehabilitation. It is also being used for specific populations including individuals who are incarcerated or who live or are stationed in remote locations.

Technical support exists for health care entities interested in pursuing telemedicine options. Telehealth Resource Centers (TRCs) have been established to assist health care organizations, health care networks, and health care providers in the implementation of cost-effective telehealth programs to serve rural and medically underserved areas and populations. TRCs were created under HRSA grants from the Office for the Advancement of Telehealth, Office of Health Information Technology. Alabama is served by the Southwest Telehealth Resource Center, which provides a wide array of services and resources, including:

- Strategic/Business Plans
- Network Structure
- Best practice models
- Locating and assessing funding sources
- Evaluation design and metrics
- Technology assessment
- Development of vendor request for proposals
- Operations and program management
- Regional legislative and regulatory issues[xiv]

A. Medicare

Most of the financing and reimbursement for telemedicine services comes from Medicare. Payments for telehealth services provided by the physician or practitioner at the distant site are equal to the current fee schedule amount for the service provided without the use of a telecommunications system. Initially, Medicare rules required that a telehealth provider be present to be eligible for Medicare reimbursement, which limited the reimbursement to "live" telemedicine services. Provisions passed in 2008 (effective January 1, 2009) expand payment for telemedicine services by not requiring a telepresenter. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law.

Current Centers for Medicare and Medicaid (CMS) regulations permit use of a telecommunications system to substitute for a face-to-face encounter for consultation, office visits, individual psychotherapy, and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are:

- Inpatient Consultations (CPT codes G0425 – G0427, G0406 – G0408)
- Office or other outpatient visits (CPT codes 99201–99205, 99211–99215)
- Psychiatric diagnostic interview examination (CPT code 90801)
- Individual psychotherapy (CPT codes 90804–90809)
- Pharmacologic management (CPT code 90862)
- Neurobehavioral Status Exam (CPT code 96116)
- Health and behavioral Assessment and Intervention (HBAI)

Health professionals eligible to claim reimbursement for remote telehealth services include physicians; nurse practitioners; physician assistants; nurse midwives; clinical nurse specialists; clinical psychologists; clinical social workers, and registered dietitians or nutrition professionals. Clinical psychologists and clinical social workers may not bill for psychotherapy services that include medical evaluation and management services under Medicare. Facilities eligible to be an originating site include the office of a physician or practitioner; a hospital; a critical access hospital; a rural health clinic; a federally qualified health center; a skilled nursing facility; or a community mental health center. ("Originating site" is where the patient is located.)

If the above conditions are met, and the Medicare beneficiary resides in, or utilizes the telemedicine system in a federally designated rural health Professional Shortage Area (HPSA); in a county that is not in a Metropolitan Statistical Area (MSA); or from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of health and Human Services as of December 31, 2000; and the patient was present and the encounter involved

interactive audio and video telecommunications that provides real-time communication between the practitioner and the Medicare beneficiary, then both an originating fee and a telehealth professional fee may be billed to Medicare.[xv]

The 2011 professional telemedicine Medicare fees are listed in the following table. The current telehealth facility originating fee is 80% of the lesser of the actual charge or $24.00.

Medicare CPT Code/Relative Values Based on 2011 CPT Codes and Medicare Payment Information for Alabama: Subset Relative to Telemedicine Delivery of Behavioral Health Services[xvi]

	Non-Facility*	Facility**
Inpatient Consultations		
G0425	$95.31	$95.31
G0426	$130.13	$130.13
G0427	$191.73	$191.73
Follow-up Inpatient Consultations		
G0406	$36.73	$36.73
G0407	$66.51	$66.51
G0408	$95.47	$95.47
Office Or Other Outpatient Visits		
99201	$38.72	$24.53
99202	$67.124	$46.62
99203	$96.90	$70.73
99204	$149.41	$119.77
99205	$186.56	$154.40
99211	$18.58	$8.80
99212	$39..04	$23.90
99213	$65.32	$47.04
99214	$85.41	$63.18
99215	$130.75	$102.37
Psychiatric Diagnostic Interview Examination		
90801	$148.02	$119.64
Individual Psychotherapy		
90804	$64.05	$52.13
90805	$72.91	$60.33
90806	$86.44	$79.81
90807	$101.25	$89.01
90808	$127.42	$120.79
90809	$142.41	$130.82
Pharmacologic Management		
90862	$55.32	$43.34
Neurobehavioral Status Exam		
96116	$87.54	$82.50
Health & Behavioral Assessment and Intervention (HBAI)		
96150	$20.62	$20.31
96151	$19.94	$19.63
96152	$18.95	$18.63

B. Medicaid

Medicaid reimbursement for telehealth services varies by state. CMS has encouraged states to incorporate telemedicine into their Medicaid programs as a means of saving on transportation costs and improving access to care, particularly for patients facing transportation barriers as a result of distance or disability. However, Medicaid law does not recognize telemedicine as a distinct service.

Alabama has enacted legislation that permits special licensure for physicians who deliver telemedicine services across State lines. Alabama does not mandate telemedicine reimbursement by private insurers, although some large national commercial payors do cover telemedicine.

In February, 2010, Alabama's Medicaid Agency announced the expansion of covered Medicaid services to include telepsychiatry. To receive telemedicine services, the patient must be referred by his or her primary care doctor or clinic to a psychiatrist who has enrolled as a telemedicine provider, and receive the service in an approved location, such as a doctor's office or clinic, hospital, community mental health center or public health department. Services provided via telecommunications technologies are not covered if the recipient has access to a comparable service within 50 miles of his/her place of residence.

Telemedicine services must include the option of an interactive audio and video system which permits confidential two-way communication. Medical services provided by telephone, email or fax do not qualify as a telemedicine service.[xvii]

Alabama has provided for additional consumer protection by requiring a prospective telemedicine recipient to specifically consent to receiving such services.

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STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***LEADERSHIP***		
CRMHC will exercise accountable leadership through engaged governance and best management practices. In order to exercise accountable leadership....		
we will...	**by...**	**and achievement will be demonstrated by...**
1. update the vision, mission and core values of CRMHC	a) understanding who we presently serve. Clinical Review Teams will review outpatient caseloads to identify who is being served by presenting problem, diagnosis, service modality, geographic location and payer source b) seeking input from employees, board members and community partners c) identifying priority populations	the adoption of a new vision, mission and core values by the CRMHC Board of Directors.
2. establish performance expectations and metrics for the Mental Health Outpatient Offices	a) selecting and communicating a minimum of one performance metric in each of the following domains for each Mental Health Outpatient Office by April 30, 2011: Clinical Service, Quality, Satisfaction, Financial Viability, b) selecting and communicating a minimum of one performance metric in each of the following domains for each **new** clinical service or support initiated in 2011. Clinical Service, Quality Satisfaction, Financial Viability. (SEE CLINICAL SERVICES AND SUPPORTS)	the use of baseline data to develop appropriate performance targets.

Legend:	Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***LEADERSHIP***		
CRMHC will exercise accountable leadership through engaged governance and best management practices. In order to exercise accountable leadership....		
we will...	**by...**	**and achievement will be demonstrated by...**
	c) when appropriate, the metric selected will be included in the Alabama Benchmarking Project so that performance may be compared with state and local benchmarks.	
3. monitor and evaluate organizational performance on a continuing basis	a) developing tools to measure **and** report performance.	Quarterly Performance Reports to CRMHC Board of Directors with the first quarterly report on August 25, 2011.
4. incorporate results into a cycle of planning and performance improvement	a) establishing a performance review process utilizing monthly meetings of the outpatient coordinators. The OP coordinators will make recommendations for improvement to the the CRMHC Leadership Team.	CRMHC's use of performance metric reports to affect positive change.

Legend:

Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***WORKFORCE DEVELOPMENT***		
CRMHC will Strengthen and enhance its workforce as a primary means to achieve quality services and organizational performance. In order to strengthen our workforce...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. update employee position descriptions and performance evaluations	a) developing measurable performance expectations for positions in mental health outpatient offices	an updated position description and evaluation for every position in mental health outpatient offices.
2. assess staff development needs on an ongoing basis and implement appropriate training	a) preparing an individualized staff development plan for each OP therapist by June 30, 2011 b) incorporating co-occurring mental health and substance abuse training as part of each therapist's staff development plan. c) preparing an individualized staff development plan for each bachelor's level employee by June 30, 2011. d) preparing a staff development plan for each support employee by August 31, 2011	an individualized staff development plan for each OP therapist. each therapist's staff development plan incorporates co-occurring training. an individualized staff development plan for each OP bachelor's level employee. an individualized staff development plan for each OP support employee.
3. revise time off policies to balance the value of legitimate needs of employees with long term financial stability	a) working with CRMHC's Personnel Committee to revise current policies. b) seeking input from employees c) reviewing the Salary and Benefit Survey completed for the Alabama Council of Community MHBs.	the adoption of revised time off policies by the CRMHC Board of Directors.

Legend: Not Started | In Progress, Not on Target | In Progress, On Target | Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***WORKFORCE DEVELOPMENT***		
CRMHC will Strengthen and enhance its workforce as a primary means to achieve quality services and organizational performance. In order to strengthen our workforce...		
we will...	**by...**	**and achievement will be demonstrated by...**
4. upgrade recruitment standards to ensure that employees and contractors have the education, training, licensure and experience to meet CRMHC's service and financial requirements.	a) seeking individuals with credentials that enable us to access other markets. b) seeking individuals with degrees from Accredited Schools of Behavioral Science. c) modifying current manpower plans and position descriptions to require certain credentials.	number of professional employed who are Licensed Clinical Social Workers, Licensed Psychologists and Licensed Profession Counselors.

Legend:

Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***FINANCE***		
CRMHC will assure financial viability and promote the growth of the organization. In order to assure financial viability...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. accumulate 1.7 million in cash reserves	a) containing expenses and maximizing revenue, including rental income from center properties	accumulating 1.7 million in cash reserves by September 30, 2011.
2. establish clear performance metrics in the area of finance	a) develop and communicate a financial performance metric for each mental health outpatient clinic by April 30, 2011 b) develop and communicate a financial performance metric for all programs, departments by April 30, 2011	each clinic's success in meeting its financial target. each program's success in meeting its financial target.
3. identify the financial reports needed to support strategic and operating goals	a) reviewing data submitted for individual metrics b) working with the software vendor to develop electronic alternatives to manual submission	each clinic's success in meeting its financial target.

Legend:	Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***QUALITY***		
CRMHC will improve the quality of clinical services and administrative functions through the systematic measurement of performance with a focus on future results. In order to improve...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. establish measures of efficiency and effectiveness for the mental health clinics	a) using the results of the active caseload review by the Clinical Review Team. b) by using the results of program evaluations, self assessments	the selection and communication of specific measures of efficiency and effectiveness.
2. monitor and report on efforts to improve efficiency and effectiveness	a) creating tools to measure and report progress	a quarterly report to CRMHC's Board of Directors that incorporates information, concerns regarding effectiveness, efficiency.
3. identify and implement one evidenced based or emerging best practice in the mental health outpatient clinics	a) reviewing the results of the active caseload review.	implementation and consistent use of at least one evidenced based practice or emerging best practice for a period of 3 months.
4. address issues affecting satisfaction for MI outpatient clinics	a) crafting a new approach of the following: (1) wait time on day of appointment for psychiatrist (2) increasing psychiatric care (3) stabilizing turnover in child and adolescent case managers (4) expanding outpatient operations hours	wait time will decrease by 50% from baseline. additional contract hours with psychiatrist. TBD by offering afterhours appointments at least one day per week in each outpatient office.

Legend: Not Started | In Progress, Not on Target | In Progress, On Target | Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***TECHNOLOGY***		
To enhance clinical, support and administrative practice through acquisition and effective application of technology. In order to enhance practice through technology...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. increase access to psychiatric care by connecting CRMHC's rural locations to private practice psychiatrist and increase primary care for mental health consumers.	a) applying for a USDA Distance Learning and Telemedicine Grant.	grant award **and** data that supports increase in access to psychiatric care. grant award and data that supports increase in access to primary care.

Legend:	Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***CLINICAL SERVICES AND SUPPORTS***		
To improve and expand the continuum of clinical supports that are self-financed and generate a margin. In order to improve and expand...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. develop apartment based residential living for persons with intellectual disabilities	a) seeking a low cost lease arrangement with a landlord that will allow CRMHC to modify the apartment to meet DMH Certification requirements	when at least one apartment is leased and occupied.
2. increase the basic living skills (BLS) program for persons with serious mental illness	a) realigning current staff to provide medically necessary basic living skills to persons with serious mental illness	when current staff is realigned and an increased level of BLS services in the amount of 50% is sustained for 3 consecutive months.
3. increase the use of group therapy in outpatient clinics as both a means of clinical support and efficiency	a) using the ongoing clinical caseload review to identify individuals who would benefit from group therapy	each therapist offering at least one specialized group weekly for 3 consecutive months.
4. establish a collaborative relationship with at least one primary care physician	a) seeking a collaborative relationship among the primary care physicians currently utilized by CRMHC consumers	when we can identify a program or distinct group of consumers whose care is coordinated with a primary care physician.
5. expand and improve child and adolescent services in the Sylacauga Outpatient Office	a) employing a full time therapist who devotes 100% of time to children and adolescents	increase the child and adolescent caseload by 50% and sustain increase for 3 consecutive months.
6. use data from the Child and Adolescent In Home Team to access $25,000 in set aside funds to offset the cost of a Child and Adolescent Therapist for Clay and Randolph Counties	a) demonstrating high demand as evidenced by the Child and Adolescent In Home data	using the set aside funds to hire a full-time Child and Adolescent Therapist for Clay and Randolph Counties.
7. improve the residential occupancy rate for residential substance abuse services.	a) aligning staff resources to support admission on or near weekends	increase residential occupancy rate by 15%.
8. explore the recovery home residential model as a potential future program	a) researching reimbursement rates and crafting a budget with an operating margin	presentation of research findings and estimated cost to CRMHC Board.

Legend:

Not Started	In Progress, Not on Target	In Progress, On Target	Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***COMMUNICATION***		
CRMHC will actively communicate the vision, mission, core values, plans and performance outcomes of the organization to its stakeholders. In order to actively communicate...		
we will...	**by...**	**and achievement will be demonstrated by...**
1. expand our website to provide up-to-date education content, current news articles and links to other resources by April 30, 2011	a) utilizing a well regarded syndication service for behavioral treatment programs	90 days of quality information, in terms of style, clarity, timeliness and appropriate content.
2. apprise public officials and community leaders about the mission of CRMHC and our role as a behavioral health provider and employer	a) building a database of public officials and community leaders b) creating connections and contacts with public officials and community leaders c) crafting a unified message to build the "CRMHC Brand"	a comprehensive database of public officials and community leaders for each city and county in the service area. face-to-face meetings, mailouts ongoing
3. communicate with our staff regarding the Strategic Plan, Performance Targets	a) utilizing the CRMHC intranet to communicate elements of the Strategic Plan b) using the CRMHC Intranet to highlight examples of employees/programs who have achieved significant progress toward goals and/or "lives", the CRMHC values c) identifying things employees use daily as communication vehicles (put mission and/or values on mouse pads, paper cubes)	consistent use of intranet to communicate plan. use of Intranet to highlight a program and/or employee quarterly. the placement of something employees use daily to communicate the mission or a core value.

Legend: Not Started | In Progress, Not on Target | In Progress, On Target | Achieved

STRATEGIC GOAL TRACKING BOARD
CALENDAR YEAR 2011

STRATEGIC INITIATIVE - ***COMMUNICATION***		
CRMHC will actively communicate the vision, mission, core values, plans and performance outcomes of the organization to its stakeholders. In order to actively communicate...		
we will...	**by...**	**and achievement will be demonstrated by...**
4. establish CRMHC's professional staff as community experts on behavioral health and disability	a) establishing a speaker's bureau to speak to businesses, community groups and others concerning a variety of behavioral health topcs tailored to specific interests/needs b) publish professional brochures regarding CRMHC services	a record of speaking engagements by speaker and topics strategic distribution of brochures.
5. provide specialized education for staff, allied health and human service organizations and interested citizens	a) offering Mental Health First Aid (MHFA) - a public education program that helps the public identify, understand and respond to signs of mental illness and substance abuse disorders	certification of at least one CRMHC employee as a MHFA Instructor **and** presentation of at least one 12 hour course by December 31, 2011.
6. provide specialized support to the communities we serve in times of crisis	a) creating a Crisis Response Team (per suggested of CRMHC's Substance Abuse Division)	identification and training of a four (4) member team by December 31, 2011.

Legend:

Not Started	In Progress, Not on Target	In Progress, On Target	Achieved